STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF MAINECARE SERVICES and
MAINE CENTER FOR DISEASE CONTROL AND PREVENTION

RFP# 201509159

PHARMACY BENEFIT MANAGER and POINT OF PURCHASE SYSTEM

RFP Coordinator: Elizabeth Heath
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From the time this RFP is issued until award notification is made, all contact with the State regarding this RFP must be made through the aforementioned RFP Coordinator. No other person / State employee is empowered to make binding statements regarding this RFP. Violation of this provision may lead to disqualification from the bidding process, at the State's discretion.

Deadline for Submitted Questions: October 23, 2015, 5:00 p.m. local time

Proposals Due: December 15, 2015 not later than 2:00 p.m. local time

Submit to:

Division of Purchases
Burton M. Cross Building, 111 Sewall Street, 4th Floor
9 State House Station, Augusta ME 04333-0009

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Public Notice

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State of Maine
Department of Health and Human Services
Public Notice for RFP # 201509159
Pharmacy Benefit Manager and Point of Purchase System

The State of Maine Department of Health and Human Services, Office of MaineCare Services and the Maine Center for Disease Control and Prevention have a requirement for a Pharmacy Benefit Manager (PBM) and Point of Purchase System (POS). In accordance with State procurement practices, the Department is hereby announcing the publication of a Request for Proposals (RFP) # 201509159 for the purchase of the aforementioned services.

A copy of the RFP can be obtained by registering and downloading at the following website: http://www.maine.gov/dhhs/rfp/index.shtml or by contacting the Department's RFP Coordinator for this project: Elizabeth Heath. The RFP Coordinator can be reached at the following email address: Elizabeth.Heath@maine.gov or mailing address: Division of Contract Management, 221 State Street, Augusta, ME 04333-0011. The Department encourages all interested vendors to obtain a copy of the RFP and submit a competitive proposal.

Proposals must be submitted to the State of Maine Division of Purchases, located at the Burton M. Cross Office Building, 111 Sewall Street, 4th Floor, 9 State House Station, Augusta, Maine, 04333-0009. Proposals must be submitted by 2:00 p.m., local time, on December 15, 2015, when they will be opened at the Division of Purchases' aforementioned address. Proposals not received at the Division of Purchases' aforementioned address by the aforementioned deadline will not be considered for contract award.

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State of Maine - Department of Health and Human Services
RFP# 201509159
Pharmacy Benefit Manager and Point of Purchase System

PART I INTRODUCTION

A. Purpose and Background

The Department of Health and Human Services (Department) is seeking proposals for a Pharmacy Benefit Manager (PBM) and Point of Purchase System (POPS) as defined in this Request for Proposals (RFP) document. This document provides instructions for submitting proposals, the procedure and criteria by which the Provider(s) will be selected, and the contractual terms which will govern the relationship between the State of Maine (State) and the awarded Bidder(s).

The Office of MaineCare Services (OMS) administers the Department's major health care financing programs and health care benefits. OMS coordinates the programs and benefits, assures that they operate under consistent policy in keeping with the Department's goals and Federal mandates, and ensures that they are administered effectively and efficiently.

The Maine Center for Disease Control and Prevention (MeCDC) maintains three (3) separate programs requiring PBM and POPS services: 1. Maine Tuberculosis (TB) Prevention and Control Program (TB Program), 2. Partnership for a Tobacco Free Maine (PTM), and 3. Acquired Immune Deficiency Syndrome (AIDS) Drug Assistance Program (ADAP). These services provide drugs to eligible Maine recipients quickly and with a minimum of barriers.

1. Office of MaineCare Services

The Office of MaineCare Services programs and health care benefits include but are not limited to: MaineCare, Maine Rx Plus, Drugs for the Elderly and Disabled, and the Pharmacy Care Management Program (PCMP), a program that intensely manages high cost drugs through outreach, education, and contact with Members, physicians, and pharmacies. In addition to the above listed programs, the PBM will assist with the enrollment of Members into Medicare Part D Plans (PDP). This includes submission of plan formulary files, step therapy and other formulary guidance, PDE (prescription drug event) data and pharmacy network files. Using this data the PBM will assist members to enroll in plans that are the best fit for the member.

For more information on OMS, please visit http://www.maine.gov/dhhs/oms/

From 1978 to 1995, pharmacy claims were received and processed through an integrated subsystem to the PBM. In 1995, the Department developed and awarded a contract to Goold Health Systems (GHS) to develop an on-line system with pharmacists. In 2010 the Department submitted an RFP for pharmacy services and awarded the contract to Goold Health Systems (GHS); this system currently manages most aspects of the pharmacy claims processing. The current contract has been renewed through June 30, 2016 with anticipation that the contract may be extended through December 31, 2016 to allow the awarded Bidder time for an implementation period. The Department intends to award a contract estimated to begin January 1, 2017, such that pharmacy claims are processed without interruption. The Department will conduct the procurement in an open and competitive manner in full compliance with State and Federal regulations and policies

The PBM will be required to send and receive data through a secure FTP site established by the Department in a format determined by the Department to its Medicaid Management Information System (MMIS) also called the Maine Integrated Health Management Solution (MIHMS).

2. Maine Center for Disease Control - Maine Tuberculosis (TB) Prevention and Control Program

The Maine Tuberculosis (TB) Prevention and Control Program works toward a goal to eliminate TB by assuring proper identification and treatment of people who have TB disease; preventing the spread of disease to others; finding, screening, and treating people exposed to those with the disease; and targeting screening and treatment to populations at high risk for TB disease.

The TB Program works in collaboration with health care providers, the public health departments and community agencies to conduct surveillance, screening, treatment, and containment activities for TB disease and Latent TB Infection (LTBI).

Anyone in the State identified as a case or a suspected case or anyone in the State identified as having LTBI is offered State-supported TB treatment services to assure successful treatment outcomes and to reduce barriers to care. Maine CDC is the payer of last resort for TB treatment services.

Patients with TB disease or LTBI are identified by community health care providers and are referred to the TB Program for treatment services. The TB Program registers these patients and establishes them as eligible recipients with the PBM. Patients may access treatment services directly or provided case management services through Maine CDC's public health nurses.

The TB Program expects the following outcomes from the successful Bidder:

i. Successful adjudication of individual drug claims with a minimum of barriers to the patient;
ii. Timely and successful troubleshooting and resolution of billing issues at the pharmacy level.

3. Maine Center for Disease Control – Partnership for a Tobacco-Free Maine (PTM)

The Partnership for a Tobacco-Free Maine (PTM) is a program area in the Division of Population Health in the MeCDC. This RFP describes claims processing responsibilities for eligible callers to the Maine Tobacco HelpLine (MTHL) following a counselor's creation of a tobacco treatment plan for the recipient. The PBM will distribute nicotine replacement therapy (NRT) medications to eligible tobacco user recipients in the State of Maine. The PBM will manage the distribution system and work collaboratively the MTHL, who screen and counsel NRT recipients. Screening of eligible recipients will be performed by the MTHL, outside the claims processing components sought through this RFP. Screening for eligibility includes discerning third party eligibility. PBM roles/responsibilities consist of six essential components:

i. Processing system;
ii. Setting reimbursements rates;
iii. Processing NRT claims;
iv. Administering the pharmacy network ;
v. Providing a support helpdesk for all of the above functions; and
vi. Delivering scheduled reports to the MeCDC and the Department

The development of the PTM arose initially from Maine tobacco tax revenue and is currently funded by a federal categorical grant and a portion of the legal settlement with tobacco companies for incurred

health care costs caused by smoking. PTM implements a comprehensive tobacco prevention and control program for the State of Maine which includes State and community interventions, health communication interventions and treatment interventions encompassing the MTHL and NRT voucher system.

The 2012 Behavioral Risk Factor Surveillance Survey (BRFSS) reported that 20.3% of Maine adults (18+ years) are current smokers. Although the rates have declined when compared to previous years, there are still subpopulations with higher rates of smoking. For example, adults enrolled in MaineCare have smoking rates at 43%, which is twice that of the general population. It is estimated that MaineCare recipients cost the State $216 million per year in tobacco-related health expenditures (http://www.tobaccofreekids.org/facts_issues/toll_us/maine). Approximately 76% of MaineCare recipients report they would like to quit using tobacco, with 97% considering quitting within the next six months and 57% considering quitting within the next 30 days (2012 BRFSS).

Since 2001, PTM has offered treatment services for tobacco dependence, including the MTHL, through a contract with MaineHealth's Center for Tobacco Independence (CTI) in Portland, ME. The MTHL is a telephone-based tobacco cessation service that provides individualized counseling and authorizes free NRT for eligible smokers who are ready to quit. The MTHL provides toll-free counseling to any tobacco user. Other callers, such as friends and family members, healthcare providers and the public are also given information and educational materials, as appropriate. In August 2002, PTM began the Tobacco Medication Voucher Program to provide access to free NRT for eligible callers.

Callers who express a readiness to quit smoking are connected to a counseling specialist, who use motivational interviewing and cognitive-behavioral counseling techniques to teach problem-solving and coping skills, increase smoker confidence and develop individual quit plans. Callers are encouraged to receive three additional follow-up calls from a counselor to reinforce and support their plan for quitting.

4. Maine Center for Disease Control – AIDS Drug Assistance Program

The Acquired Immune Deficiency Syndrome (AIDS) Drug Assistance Program (ADAP) provides eligible low-income people throughout Maine with prescription drugs for the treatment of Human Immunodeficiency Virus (HIV) and AIDS including related conditions. ADAP is the payer of last resort, filling financial gaps in care for people who are uninsured or underinsured to assist with uninterrupted access to life-prolonging drugs. The PBM will help ADAP ensure that Mainers requiring these programs receive drugs quickly and with a minimum of barriers.

Since the 1990s, the State of Maine has provided ADAP services funded primarily through federal funds from the Health Resources and Services Administration (HRSA). ADAP is directed by the federal Ryan White HIV/AIDS Program legislation (http://hab.hrsa.gov/abouthab/legislation.html).

Eligibility for ADAP, including verification of HIV status, residency, income and insurance status, is determined and monitored by the Department bi-annually. Active members may obtain approved prescription drugs from the program's formulary at any of a large number of retail pharmacies statewide, including chains and independent pharmacies, as well as mail order pharmacies and a small number of hospital pharmacies.

Approximately 95% of ADAP members utilizing the program are enrolled in various public and private insurance plans that serve as the primary payer for members' prescription drugs. Claims must be

coordinated to ensure all other payers are billed prior to ADAP (in some cases, ADAP is the third or fourth payer). Claims for the remaining 5% of utilizing members are comparatively simple, because ADAP is the sole payer. ADAP currently has 815 enrolled members with about 82% actively utilizing the program. In 2014, ADAP had an average of 124 claims per month, including reversals, totaling an average of about $106,920 per month. The number of members and claims varies with a steady upward trend for the last several years. Bidders should use these estimated numbers as baseline assumptions in preparing cost projections.

ADAP expects the following outcomes from the Bidder:

i. Successful adjudication of individual drug claims with a minimum of barriers to the client;
ii. Management and collection of manufacturers' rebates on prescription drugs as allowed by the 340B Drug Pricing Program to ensure the financial stability of the program; and
iii. Timely and successful troubleshooting and resolution of billing issues at the pharmacy level.

B. General Provisions

1. Issuance of this RFP does not commit the Department to issue an award or to pay expenses incurred by a Bidder in the preparation of a response to this RFP. This includes attendance at personal interviews or other meetings and software or system demonstrations, where applicable.
2. All proposals should adhere to the instructions and format requirements outlined in this RFP and all written supplements and amendments (such as the Summary of Questions and Answers), issued by the Department. Proposals are to follow the format and respond to all questions and instructions specified below in the "Proposal Submission Requirements and Evaluation" section of this RFP.
3. Bidders shall take careful note that in evaluating a proposal submitted in response to this RFP, the Department will consider materials provided in the proposal, information obtained through interviews/presentations (if any), and internal Departmental information of previous contract history with the Bidder (if any). The Department also reserves the right to consider other reliable references and publicly available information in evaluating a Bidder's experience and capabilities. The proposal shall be signed by a person authorized to legally bind the Bidder and shall contain a statement that the proposal and the pricing contained therein will remain valid and binding for a period of 180 days from the date and time of the bid opening.
4. The RFP and the selected Bidder's proposal, including all appendices or attachments, shall be the basis for the final contract, as determined by the Department.
5. Following announcement of an award decision, all submissions in response to this RFP will be considered public records available for public inspection pursuant to the State of Maine Freedom of Access Act (FOAA) (1 M.R.S. §§ 401 et seq.). http://www.mainelegislature.org/legis/statutes/1/title1ch13sec0.html
6. The Department, at its sole discretion, reserves the right to recognize and waive minor informalities and irregularities found in proposals received in response to this RFP.
7. The State of Maine Division of Purchases reserves the right to authorize other Departments to use the contract(s) resulting from this RFP, if it is deemed to be beneficial for the State to do so.
8. All applicable laws, whether or not herein contained, shall be included by this reference. It shall be Proposer's/Vendor's responsibility to determine the applicability and requirements of any such laws and to abide by them.

C. Eligibility to Submit Bids

Public agencies, private for-profit companies, and non-profit companies and institutions are invited to submit bids in response to this Request for Proposals.

Bidder cannot have a current affiliation or contractual relationship with a tobacco company. This includes any tobacco-related entity such as owners, affiliates, subsidiaries, holding companies or companies involved in any way in the production, processing, distribution, promotion, sale or use of tobacco.

D. Contract Term

The Department is seeking a cost-efficient proposal to provide services, as defined in this RFP, for the anticipated contract period defined in the table below. Please note that the dates below are estimated and may be adjusted as necessary in order to comply with all procedural requirements associated with this RFP and the contracting process. The actual contract start date will be established by a completed and approved contract.

Contract Renewal: Following the initial term of the contract, the Department may opt to renew the contract for (3) three renewal periods of two years each, subject to continued availability of funding and satisfactory performance.

The term of the anticipated contract, resulting from this RFP, is defined as follows:

Period	Start Date	End Date
Implementation Period	03/01/2016	12/31/2016
Initial Period of Performance	01/01/2017	12/31/2018
Renewal Period #1	01/01/2019	12/31/2020
Renewal Period #2	01/01/2021	12/31/2022
Renewal Period #3	01/01/2023	12/31/2024

E. Number of Awards

The Department anticipates making one (1) award as a result of this RFP process.

F. Definitions/Acronyms

Acronym/Term	Definition
340B Drug Pricing Program	A federal program authorized under section 340B of the Public Health Service Act (see 42 U.S.C. 256b) requiring drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at reduced prices. For more information: http://www.hrsa.gov/opa/
ADAP	Maine's Acquired Immune Deficiency Syndrome Drug Assistance Program
ADAP Crisis Task Force (ACTF)	An entity authorized to negotiate reduced drug prices for the ADAP
AIDS	Acquired Immune Deficiency Syndrome (AIDS)
Analysis	The examination and evaluation of relevant information to select the best course of action from among various alternatives.
ACSII txt Delimited File	A file that contains data made up of ASCII characters. It is essentially raw text. Each byte in the file contains one character that conforms to the standard ASCII code.
Average Wholesale Price (AWP)	A benchmark used for pricing and refers to the average price at which drugs are purchased at the wholesale level.
Best Price	The lowest price at which the pharmaceutical company sells its drug.
BRFSS	Behavioral Risk Factor Surveillance Survey
CAREWare	Microsoft SQL-based database used by ADAP
Carve-Out Mental	A program that contracts directly with managed behavioral health organizations

Health Program	regarding a mental health program separately form the remaining health care benefit package.
Configuration	The way a system is set up, or the assortment of components that make up the system. Configuration can refer to either hardware or software, or the combination of both.
Claim	Individual transaction related to payment of prescription medications
CMS	Centers for Medicare and Medicaid Services
CTI	Center for Tobacco Independence (MaineHealth, Portland, Maine)
Day Supply Limitation	A limitation upon eligible recipients of receipt of thirty (30) doses of drug(s) per 30 days, subject to a valid override authorized by the TB Program
DEA	Drug Enforcement Agency is a federal agency responsible for enforcing laws and regulations governing narcotics and controlled substances.
Deployment	A general process that has to be customized according to specific requirements or characteristics to make all the supporting systems ready to use.
Department	Maine Department of Health and Human Services.
DESI	The Drug Efficacy Study Implementation Program of the Food and Drug Administration (FDA).
Disease Management Program	Multidisciplinary efforts to improve the quality and cost-effectiveness of care for selected patients suffering from chronic conditions. This program involves interventions designed to improve adherence to scientific guidelines and treatment plans.
Dispensing Fee	A fee that compensates the pharmacy for transferring the drug from the pharmacy to the patient; overhead, such as stocking and storing medications; and patient counseling.
DOT	Direct Observed Therapy. A therapy method where an eligible recipient is observed ingesting medication. This is a requirement for recipients of the TB Program.
Drug Rebate	An offset to the Federal and State costs of most outpatient prescriptions drugs dispensed to patients that is negotiated with manufacturers.
DRS	Designated Record Set.
DUR	Drug Utilization Review is an authorized, structured, ongoing comprehensive review of patient's prescription and medication data.
ePHI	Electronic Protected Health Information.
E-Prescribing	A technology framework that allows physicians and other medical practitioners to write and send prescriptions to a participating pharmacy electronically instead of using handwritten or faxed notes or calling in prescriptions.
Exchange	Health insurance marketplaces established as part of the Affordable Care Act
FDA	Federal Drug Administration
FEIN	Federal Employment Identification Number.
FFP	Federal Financial Participation.
Formulary	List of approved and covered drugs for which claims may be paid
FTP	File Transfer Protocol (secure file transfer).
HIPAA 5010 x12	Health Insurance Portability Accountability Act standards for the electronic transmission of specific healthcare transactions, including eligibility, claim status, referrals, claims, and remittances.
HIT	Health Information Technology.
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
IBM	Intensive Benefit Management. A program described in MaineCare Benefits Manual Ch. II, section 80.07-5 that identifies and manages members who are shopping for prescription drugs by receiving certain prescriptions from multiple physicians and/or having prescriptions filled at multiple pharmacies.
ICD-10	The International Classification of Diseases, Tenth Revision. A system of coding created by the World Health Organization that notes various medical records including

	diseases, symptoms, abnormal findings and external causes of injury.
LIS	Low Income Subsidy benefitting Medicare beneficiaries with limited resources who qualify for extra help with Prescription Drug Plan costs.
Lock-In Program	A program established by MaineCare Benefits Manual Ch. IV that denies claims for payment of services outside the established restriction, such as limiting the MaineCare Member to acquiring medications at only one (1) pharmacy. This is used in such instances as where a Member is inappropriately purchasing the same drug at several locations.
LTBI	Latent Tuberculosis Infection
MAC	Maximum Allowable Cost refers to a payer or PBM-generated list of products that includes the upper limit or maximum amount that a plan will pay for generic drugs and brand name drugs that have a generic versions available (multi-source brands).
MaineCare	Maine's Medicaid Program.
Manual Pricing Intervention	The activity of entering a price in the system manually as opposed to the price being automatically updated.
MCO	Managed Care Organization is an organization that combines the functions of health insurance, delivery of care, and administration.
MeCDC	Maine Center for Disease Control and Prevention
Member	An individual who receives MaineCare (Medicaid).
MIHMS	Maine Integrated Health Management Solution: a system that processes Medicaid claims.
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub.L. 108-173 (codified as amended at 42 U.S.C. §§ 139A, 223, 299b-7, 1395-96, 4980G (2006)).
MMIS	Medicaid Management Information System: a system that processes Medicaid claims.
MTHL	Maine Tobacco HelpLine. The free telephonic hotline that provides tobacco treatment and information for quitting the use of tobacco for Maine residents.
MTHL-Eligible Caller	A person calling the Maine Tobacco Helpline who meets PTM eligibility guidelines for NRT as a tobacco user who is: 1) ready to quit in the next 30 days, 2) age 18 or older 3) not pregnant or planning pregnancy and 4) without health insurance or insurance benefits for pharmacotherapy.
NCPDP	National Council for Prescription Drug Programs is a not-for-profit, American National Standards Institute (ANSI) -accredited, standards-development organization that has created a telecommunication standard and a batch standard for electronic processing of pharmacy claims.
NDC	National Drug Code is a unique 10-digit, 3-segment number that is a universal product identifier for human drugs in the United States.
NPI	National Provider Identifier is a unique ten-digit identification number required by HIPAA for all health care providers in the United States that providers must use to identify themselves in all HIPAA transactions.
NRT	Nicotine Replacement Therapy. One of three FDA medications (patch, gum, lozenge) to be dispensed to the MTHL-eligible callers.
OIT	Office of Information Technology.
OMS	Office of MaineCare Services: a division within the Department that directly manages the PBM contract.
Operations	Hosting and operational functions, services, maintenance, and staffing.
PA	Prior Authorization is a cost-containment procedure that requires a prescriber to obtain permission to prescribe a medication prior to prescribing it. See MaineCare Benefits Manual Ch. I, section 1.14 and Ch. II, section 80.07-4.
PBM	Pharmacy Benefits Manager is an intermediary that screens for eligibility and adjudicates pharmacy claims.

PCMP	Pharmacy Care Management Program is a program that manages a distinct service or group of services that optimize therapeutic outcomes for individual patients.
PDE	Prescription Drug Event.
PDL	Preferred Drug List. A listing of covered drugs setting forth such information status as preferred or non-preferred, whether prior authorization is required, step order, and any other information as determined by the Department to be helpful to members, pharmacists, prescribers and other interested parties. See MaineCare Benefits Manual Ch. II, section 80.07-5.
PDP	Part D Prescription Drug Plan is a drug benefit offered under the Medicare Program.
Pharmacy Network	Approved pharmacies in contract with the PBM agreeing to its terms for processing claims, including assurance that appropriate translation and interpreter services are available to eligible recipients who have language barriers.
PHN	Public Health Nursing
PIU	Program Integrity Unit. The unit within the Maine Department of Health and Human Services, Division of Audit, responsible for conducting a federally required monitoring plan that reviews all MaineCare services and expenditures.
PMP	Project Management Professional.
POPS	Maine's Point of Purchase System. The system that adjudicates pharmacy claims.
POS	Point of Sale; a term used interchangeably with POPS, the system that adjudicates pharmacy claims.
PRO-DUR	Prospective Drug Utilization Review (see Part II, W, 4 for description).
PTM	Partnership for a Tobacco Free Maine
QA	Quality Assurance is a systematic process of assessing whether the product or service is meeting specified requirements.
RAC	Recipient Aid Category is a coding used for specific billing purposes
Remotely Hosted	Hosted other than on the State of Maine Wide Area Network (WAN).
Retro-DUR	Retrospective Drug Utilization Review (see part II, W, 6 for description).
SSAE 16 SOC 2 Type 2 Annual Audit	Statement on Standards for Attestation Engagements (SSAE) No. 16 is an attestation standard put forth by the Auditing Standards Board (ASB) of the American Institute of Certified Public Accountants that addresses engagements undertaken by a service auditor for reporting on controls at organizations that provide services to user entities, for which a service organization's control are likely to be relevant to user entities internal control over financial reporting (ICFR)
SPAP	A state program which, in determining eligibility and the amount of assistance to a Part D eligible individual under the program, provides assistance to such individuals in all Part D plans, does not discriminate based upon the Part D plan in which the individual is enrolled and otherwise meets the requirements of 42 U.S.C.§ 1395w-133(b).
SSDC	Sovereign States Drug Consortium is a Medicaid supplemental drug rebate program in which Maine, Iowa, Vermont, Utah, Wyoming, West Virginia, Oregon, Delaware, North Dakota and Mississippi pool their prescription utilization numbers to obtain supplemental rebates from pharmaceutical manufacturers.
Step-Care	A therapeutic program that begins with a simple, conservative type of treatment but may advance to more complex stages as needed to achieve control of a disease or disorder.
Supplemental Rebate	The rebate from a pharmaceutical manufacturer pursuant to a drug rebate agreement authorized by 22 M.R.S. § 3174-Q.
TB	Tuberculosis
TB Program	Maine Tuberculosis Prevention and Control Program
TPL	Third Party Liability. TPL refers to insurance coverage for the legal liability of one party to another party.
TrOOP	True Out of Pocket Expense. Payments that count toward a person's Medicare drug plan out-of-pocket threshold and determine the level upon which catastrophic coverage

	will begin. (2015 – TrOOP $4,700)
WAC	Wholesale Acquisition Cost (i.e. List Price)
X-DEA	A Drug Enforcement Administration number assigned to a qualifying physician necessary to prescribe medication-assisted opioid therapy.

PART II SCOPE OF SERVICES

This section describes the scope of work from which Bidders should prepare their proposals. The work, as it is defined below, will be incorporated into the contract resulting from this competitive procurement. The successful Bidder will be responsible to ensure that the work is performed to completion in accordance with the contract terms and conditions.

The Bidder must provide a solution for the analysis, configuration, testing, training and implementation of a replacement system for the Pharmacy Benefit Manager (PBM) for the State of Maine, Department of Health and Human Services (Department) Office of MaineCare Services and Maine Center for Disease Control and Prevention. All requirements of services identified below must be addressed in a submitted proposal.

GENERAL REQUIREMENTS – OFFICE OF MAINECARE SERVICES

SECTIONS A-T ARE REQUIREMENTS THE BIDDER MUST MEET AS PART OF ITS CONTRACT WITH THE STATE. BIDDERS DO NOT HAVE TO PROVIDE A WRITTEN RESPONSE FOR SECTIONS A-T IN THEIR WRITTEN PROPOSAL, HOWEVER BY PROVIDING A RESPONSE, BIDDERS AGREE TO PROVIDE SERVICES IN ACCORDANCE WITH SECTIONS A-T. SEE PART II. SECTION U FOR PROPOSAL REQUIREMENTS TO BE ADDRESSED.

1. CONTRACT REQUIREMENTS – OFFICE OF MAINECARE SERVICES

A. System Certification

The successful Bidder must provide a fully certified system in accordance with the criteria below:

The new Maine PBM must, throughout the implementation period, initial period of performance and all renewal periods, meet all certification and recertification requirements established by the Centers for Medicare and Medicaid Services (CMS). The PBM shall ensure that Federal certification approval for the maximum allowable enhanced Federal Financial Participation (FFP) is obtained retroactively to the day the system becomes operational and is maintained throughout the term of the Contract.

Title 42 U.S.C. section 1396b(a)(3)(B) provides seventy-five percent (75%) FFP for operation of mechanized claims payment and information retrieval systems approved by CMS.

Should decertification of the PBM, or any component of it, occur prior to contract termination or the ending date of any subsequent contract extension, the PBM shall be liable for the loss of FFP to the State and other related damages.

For any violation of section A. the PBM shall be liable for the State and Federal dollar difference between the maximum allowable enhanced FFP and that actually received by the Department, including any losses due to loss of certification, failure to obtain approval retroactive to day one (1), or delays in readiness to support certification.

All FFP reductions imposed by CMS shall be withheld from monies payable to the PBM until certification is achieved. Penalty assessments shall not be made by the State until CMS has completed its certification approval process and notified the State of its decision in writing. The PBM shall support the Department in preparing and submitting its request for CMS certification review and approval, including preparing all documentation and operational examples to demonstrate criteria are met; that the system addresses all business functions, performance standards, and business model expectations for certification.

B. Health Care Portability and Accountability Act of 1996 (HIPAA)

The successful Bidder shall deliver systems and services that are compliant with Title II, Subtitle F, Section 261-264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, titled "Administrative Simplification" (codified at 42 U.S.C. § 1320d) and the rules and regulations promulgated thereunder. In addition, the successful Bidder shall ensure compliance with all HIPAA requirements across all systems and services related to this procurement, including transaction, common identified, and privacy and security standards, by the effective date of those rules and regulations. The successful Bidder shall comply with the rules and regulations, and will implement these rules and regulations to achieve consistency in data collection, validation, storage, retrieval, and consolidation with all Department programs.

To the extent the successful Bidder is considered a Business Associate under HIPAA; the Bidder shall execute and deliver in form acceptable to the Department a Business Associates Agreement (BAA).

C. Business Operational Office Location

The successful Bidder's business offices must be located within thirty (30) minutes of the greater Augusta area, or must have the ability and commit to establish a location 30 days prior to contract start date. The data center operations may be located outside the State of Maine in an existing vendor supplied data center. The successful Bidder must maintain the capacity through its business offices to meet the following criteria:

1. Staff and administer the monthly Drug Utilization Review (DUR) meetings;
2. Recruit and provide professional staff to advise on the DUR board;
3. Hold in-person bi-monthly meetings with the Director of Operations and other key staff;
4. Analyze and advise on proposed legislation;
5. Operate he Pharmacy Care Management (PCM) program collaborating with the local provider community;
6. Provide continuous daily contact with Maine Health Information Management System (MIHMS); and
7. Provide clinical expertise at Administrative Hearings.

D. Systems Hosting

The system proposed will be remotely hosted and the successful Bidder will provide, house, install, and configure all applicable software and system components including hardware, operating systems, and storage media needed to satisfy the requirements specified within this RFP. The system must be consistent with the Department's current application architecture in Appendix F.

E. Changes in Architecture

The successful Bidder will give the Department at least thirty (30) days advance written notice of any material change in its network operations or architecture.

A planned material change in network operations or architecture cannot be made without the prior written consent of the Department. A "material change" includes, but is not limited to, a substantial change which increases response time to inquiries, adds to the complexity of network use, diminishes services provided to users, or results in a comparable impact on operations noticeable by users.

F. Testing

The successful Bidder must develop a plan for system and user acceptance testing which will include a

minimum one (1) month pilot. The Bidder shall provide cases and develop test scripts to fully test the system.

Prior to moving the solution to the Production Environment, the successful Bidder shall test all aspects of the solution in accordance with the State's Deployment Certification Policy for Major Application Projects. The successful Bidder shall include deployment certification tasks on its work plan. The successful Bidder is responsible for ensuring the system is fully secure for all work provided under this procurement.

The successful Bidder shall be responsible for scheduling and coordinating all activities to ensure that each of the tests is prepared for and performed in accordance with the system and user acceptance testing plan. The successful Bidder shall appropriately train Department personnel to participate in the testing effort. Unless specified otherwise within the system and user acceptance testing plan, the successful Bidder shall be required to provide all tools, testing materials, and resources necessary to effectively perform the required tests.

G. Training

The successful Bidder shall be required to provide a training plan. The successful Bidder will be responsible for scheduling, coordinating, and delivering all training in accordance with the plan. The successful Bidder will provide the training lab. The Bidder shall train the following groups of individuals:

- End-Users – Various groups of providers (pharmacy staff, physician office staff, etc.)
- Help Desk staff users – such as Department call center staff
- Technical/Application Support – Individuals who will be providing technical/application first level support (e.g. End Users, Technical Support Specialists, and Customer Service Support). Problems and questions that cannot be addressed will be forwarded to the successful Bidder as part of maintenance and support.

H. Implementation

The successful Bidder shall implement the solution within a production environment. The successful Bidder shall be required to create and submit a plan to accomplish the implementation.

The successful Bidder shall be responsible for scheduling and coordinating all activities to ensure that the implementation is performed in accordance with the plan.

I. Technical Support and Maintenance

The successful Bidder shall provide support and maintenance for the PBM to begin immediately after receiving the State of Maine's official acceptance.

As part of the support, the successful Bidder shall address all questions and problems related to the technical and functional operation of the system. The successful Bidder shall provide toll-free telephone support during regular business hours Monday through Friday, 8:00 a.m. to 5:00 p.m. local time (EST). A qualified technician with knowledge, training, and experience with the MEPOP system will respond via telephone. The successful Bidder shall offer on-site technical support within one (1) business day for problems that cannot be resolved via telephone.

As part of the maintenance, the successful Bidder shall provide all materials and labor associated with enhancing the PBM. Enhancements are defined to include any patches, upgrades, and major software releases that improve the technical and functional operation of the system beyond that which was delivered as part of the implemented PBM.

J. Documentation

Documentation will include any standard product documentation and documentation of additional configuration and customization required by the RFP. All documentation will be provided in accordance with the terms and conditions specified within this RFP and any resulting agreements. The Department requires the Bidder to maintain an electronic storage of project documentation and provide online access to the State.

K. Change Management

The successful Bidder's Project Manager will be required to formally document and track all changes to the functional design, technical design, and/or approved deliverables. For each change, the successful Bidder's Project Manager shall work closely with the Department's Project Manager to define and document the change, its benefits, and if necessary, its impact to the project schedule and budget. All changes that impact the terms and conditions of the contract or the project scope and budget as defined within the contract will need to be addressed in accordance with the Contract Administration and Conditions defined within Part VI of this RFP. No work associated with a documented change will begin without first receiving written authorization from the Department's Project Manager.

L. Issue Management

The successful Bidder's Project Manager shall be required to formally document and track all issues that are known or reasonably should be known that will threaten the project schedule. For each issue identified, the successful Bidder's Project Manager shall work closely with the Department's Project Manager to clearly document the issue. At a minimum, the resulting document must clearly reflect the details related to the issue, the potential impact to the project schedule if the issue is not resolved, options and a recommendation for resolving the issue, a date by which the issue must be resolved, the entity responsible for resolving the issue, and the final approved resolution.

M. Risk Management

The successful Bidder's Project Manager shall be required to formally document and track risks and mitigation strategies throughout the duration of all resulting Agreement(s). In the early stages of the project, the successful Bidder's Project Manager shall be required to provide a risk management plan that will include but not be limited to:

1. Description of the identified project risk;
2. Description of the potential impact to the project;
3. Impact rating (e.g. High, Medium, Low);
4. Likelihood of occurrence (e.g. High, Medium, Low);
5. Description of risk mitigation plan; and
6. Department Approved mitigation plan.

The risk management plan shall clearly indicate the priority for addressing the risks defined. The successful Bidder shall be required to provide the initial risk management plan within the implementation period. From that point forward, the successful Bidder's Project Manager shall be required to present an updated risk management plan on a periodic basis throughout the duration of all resulting agreement(s). The timeline for delivering an updated risk management plan shall be defined in writing and approved by the Department's Project Manager immediately after delivery of the initial risk management plan.

N. Warranty

The warranty will encompass, at a minimum, correction of defective software, functionality, and procedures that were considered to be within the scope of this RFP at no additional cost to the Department as further defined in Part VI, Contract Administration and Conditions, of this RFP.

System acceptance of the solution will occur following system implementation and demonstration that the system successfully provides all the functionality required by the Department; the system meets or exceeds the performance standards in the contract; the system meets or exceeds deployment certification, the system meets HIPAA requirements, and the system meets or exceeds all criteria required for successful certification by CMS.

O. Transition and Turnover Tasks

Upon contract termination or expiration of the initial period of performance and/or all optional renewal periods, the successful Bidder shall provide, at no extra charge, assistance in turning over the PBM system to the Department or its designated agent. At a minimum the Bidder shall provide nine (9) months of service after expiration of the last contract renewal to convert to a new PBM. Turnover Tasks are described in item P.

P. Develop a Point of Purchase System (POPS) Turnover Plan

The continuing provision of PBM services requires that there be no disruption of services during a turnover from the successful Bidder to the Department or to a successor Bidder, if any, at the expiration of the initial or renewal term, or at the termination of the contract. Accordingly, the successful Bidder shall cooperate fully in providing for an orderly and controlled transition to the Department or to a successor Bidder and shall minimize any disruption in the services to be performed under this contract.

Notwithstanding any other provision in this contract, the successful Bidder shall continue providing services until the Department determines that the Department or a successor Bidder is prepared to fully assume the Bidder's duties and obligations under this contract. All the terms and conditions of the contract will apply during this period unless otherwise directed in writing by the Department.

Bidders shall provide a turnover plan to the Department. The plan shall include:

1. Bidder's proposed approach to turnover;
2. POS System Requirements Statement
3. Updates on a periodic basis
4. Approach to providing Post-Turnover Services
5. Turnover Task Deliverables Description
    a. Turnover Plan.
    b. PBM Requirements Statement.
    c. POS System software, files, and operations documentation.
    d. Turnover Results Report.

Q. Requirements

All Bidders should use their expertise in PBM Services to ensure that any other requirements necessary to implement and operate the PBM services beyond those stated by the Department are included and considered in all aspects of their proposal.

Although requirements have been defined, the Department's philosophy is to work with the successful Bidder to re-evaluate these requirements and related work practices, make appropriate changes to current work flows, and, if appropriate or applicable, change policy to allow use of work practices more closely aligned with the successful Bidder's base solution.

R. General/Detailed System Design

Bidders shall provide a high level schematic proposed system design and approach to developing the General/Detailed System Design.

Bidders shall be required to develop and submit a General/Detailed System Design to the Department for review and approval that meets all system requirements listed in the scope of work.

S. Conversion

Bidders shall propose and develop a plan to convert the Department's data necessary to operate the new PBM and must include an approach to testing conversion programs that is to be reviewed and approved by the Department. Bidders shall provide testing results to the Department for review and approval.

T. Deliverable Submission and Review for Work Plan

1. Deliverable Expectation Agreement

The Department will work in cooperation with the successful Bidder to define the format and expected content for each deliverable which shall be defined as requirements under the resulting contract. The Bidder does not have to perform this requirement in order to be eligible to submit a bid. A formal and written agreement related to the format and content for each deliverable and a detailed work plan will be made before any work begins to produce the deliverable.

2. Deliverable Submission

Two (2) paper copies and two (2) electronic copies in word format on CD of each deliverable shall be submitted to and received by the Department's Project Manager on or before the due date specified in the approved Project Work Plan.

3. Deliverable Review

The successful Bidder will work with the Department to ensure that all deliverables are reviewed and approved in accordance with the following procedure:

- As soon as possible, but not later than ten (10) workdays after the date of receipt of the deliverable, the Department's Project Manager shall give written notice to the successful Bidder of the approval or disapproval. Notice of disapproval will state the reasons for such disapproval and will indicate the nature and extent of the corrections required to qualify the deliverable for approval.
- As soon as possible, but not later than five (5) workdays after receipt of a notice of disapproval, the successful Bidder shall make the corrections and resubmit the corrected deliverable for review.
- As soon as possible, but not later than five (5) workdays following resubmission of any previously disapproved deliverable, the Department's Project Manager shall give written notice to the successful Bidder's Project Manager of the approval or disapproval of the deliverable. Notice of disapproval will state the reasons for such disapproval and will indicate the nature and extent of the corrections required to qualify the deliverable for approval.
- The Department's Project Manager and the successful Bidder's Project Manager shall work together to ensure that appropriate action is taken to resolve all remaining issues and bring the review process to conclusion. Approval of the deliverable shall be given no later than three (3)

workdays following the latest notice of disapproval.

In extraordinary circumstances, the Department may require additional deliverable review time, beyond those periods detailed in this section. In such circumstances, the Department's Project Manager will identify the additional review period required and submit notification, in writing, to the successful Bidder. Any changes in the successful Bidder's tasks and/or schedule in the Project Work Plan (other than those resulting from additional deliverable review times required by the Department) must be approved by the Department's Project Manager.

During the review of key deliverables and/or upon the Department's approval of key deliverables, the successful Bidder shall, at the request of the Department's Project Manager, provide structured walkthroughs of the deliverable being reviewed or of the entire solution completed to that point, including copies of documentation and any visual aids. The successful Bidder shall conduct each walkthrough at a time and place convenient to the Department and Federal personnel in attendance as specified by the Department's Project Manager.

2. SERVICE REQUIREMENTS – OFFICE OF MAINECARE SERVICES

U. Scope of Work

ALL BIDDERS MUST RESPOND IN DETAIL HOW THE FOLLOWING WILL BE PROVIDED

The PBM (Successful Bidder) must be implemented on existing POS computers at all MaineCare pharmacy providers and must interface with the Department's operated Maine Integrated Health Management Solution (MIHMS) where adjudicated claims are finally processed and paid and Department Federal reports are produced. This section of the RFP includes a description of the requirements, both functional and technical, that must be met. In each of the tasks identified below, Bidders must explain in detail how tasks will be accomplished.

1. The PBM must maintain interfaces between the POS and comprehensive, accurate, and up-to-date data sources required to approve and adjudicate claims according to NCPDP standards. The PBM must also maintain interfaces between POS and reporting applications, e.g., Federal reporting, data warehouse/decision support, drug manufacturer rebate invoicing, program integrity, and others. In addition the PBM must complete the following tasks;

    a. The PBM must provide real-time access to MaineCare member eligibility.
    b. The PBM shall implement a daily eligibility verification process with the Department's MMIS. The PBM shall accept eligibility files in a layout and on a schedule determined by the Department and in a secure manner as determined by the Department.
    c. The PBM must provide real-time access to provider eligibility, including the pharmacy and prescriber National Provider Identifier (NPI) and authorization IDs for electronic submission of claims.
    d. The PBM shall receive and maintain a provider file in the format determined by the Department. The PBM shall verify that the prescriber is a MaineCare provider through identification of the MaineCare ID and NPI. The PBM shall provide a report to the Department monthly showing all prescribers that have prescribed to a MaineCare member but are not a MaineCare provider.
    e. The PBM must provide real-time access to the State's drug and formulary file or maintains an up-to-date copy for POS use.
    f. The Department requires that the PBM maintain the State's preferred drug list and provide up-to-date file for POS use. The PBM shall be responsible to maintain an up-to-date file on an accessible website. This file will be built in a manner that allows provider's access to the listing of all drugs on the PDL with a description of each as it relates to being preferred or non-preferred

and will include step therapy information. An example of what the Department requires may be seen at www.mainecarepdl.org.

g. The PBM must provide real-time access to benefit business rules.
h. The PBM must provide real-time access to drug file and pharmacy claims history.
i. The PBM must ensure that all pharmacy claims are assigned a unique identification number upon entering the system.
j. The PBM must interface with the MMIS or other payment system designated by the Department to maintain records of time of claims payment in order for the payment systems to pay claims within thirty (30) days after receipt by the POS system of an error free claim.

   The system and related manual procedures must provide confidentiality of the information being processed, for both providers and clients of the MaineCare Program. This confidentiality must be in compliance with the requirements of CMS State Medicaid Manual (SMM) Part 2, section 2080.18(D) link: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html Select Chapter II – Medicaid Management Information System or at this link http://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/P45_11.zip

k. The POS must have sufficient flexibility to allow for changes in criteria and standards, as well as possible future program initiatives such as a pharmacy case management system.
l. The PBM must analyze relative cost-effectiveness of all drugs driving drug benefit cost increases. The PBM must differentiate savings due to Prior Authorization, Third Party Liability (TPL) cost Avoidance, Maine Maximum Allowed Cost, Four Brand Limit, Drug Management and other initiatives that may be implemented.

2. The POS must ensure timely and accurate adjudication of provider claims. All POS pharmacy claims must be processed within nine (9) seconds from receipt 95% of the time abiding by the following standards.

   a. The POS must perform online real-time capture and adjudication of pharmacy claims submitted by providers via POS devices, a switch, or through the Internet. The POS must accept ASC X12N NCPDP claims required by 45 C.F.R. Part 162.
   b. The PBM will be required to be up-to-date at all times on current software and format requirements such as the National Council for Prescription Drug Program (NCPDP) updates, ICD-10 code sets as they pertain to pharmacy, and 5010 (Health Insurance Portability and Accountability Act (HIPAA) x 12 Version 5010). 5010 is a uniform standard for exchanging health care transactions via electronic data interchange. OMS intends to move to sharing health information electronically, and the PBM must be able to participate using 5010 standards.
   c. The POS must return to the pharmacy provider the status of the claim and any errors or alerts associated with the processing, such as the following:

      1. Edit failures.
      2. PRO-DUR alerts.
      3. MaineCare member or coverage restrictions.
      4. Prior authorization missing.
      5. Required coordination of benefits.
      6. Refill too soon.
      7. Requires generic substitution.
      8. Deny experimental drugs.
      9. Requires unit measurements (does or does not).
      10. Package size not approved.
      11. Drug efficacy study.

12. Implementation (DESI) is not covered.

d. The POS must verify that the MaineCare member is eligible on the date of service and not otherwise restricted, e.g., enrolled in MCO or a Lock In program, or receiving medication through a waiver program, a carve-out mental health program, or a disease management program.
e. The POS must verify that the pharmacy provider is eligible on the date of service.
f. The POS must verify that all fields defined as numeric contain only numeric data.
g. The POS must verify that all fields defined as alphabetic contain only alphabetic data.
h. The POS must verify that all dates are valid and reasonable.
i. The POS must verify that all data items which can be obtained by mathematic manipulation of other data items agree with the results of that manipulation.
j. The POS must verify that all coded data items consist of valid codes, including National Drug Code (NDC) for drug codes.
k. The POS must verify that required data items are present and retained (See CMS State Medicaid Manual page 11375 at http://www.google.com/url?url=http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html&rct=j&frm=1&q=&esrc=s&sa=U&ei=gjZnVeCmE4PLsASOu4D4CA&ved=0CBQQFjAA&usg=AFQjCNGfBV4eYHbs5cn6k00r3y6d5juQ9g), including all data needed for State or Federal report requirements.
l. The POS must verify that the date of service is within the allowable time frame for payment.
m. The POS must demonstrate that individual drugs and compounds which indicate a need for manual pricing intervention are flagged for review.
n. The POS must have the ability to process compound claims online.
o. The POS must verify that the pharmacy claim is not a duplicate of a previously adjudicated claim or claim paid for with cash that would disqualify the claim if the cash claim had been submitted for reimbursement on reporting of all such claims
p. The POS must authorize payment according to Maine's Medicaid State Plan at the lesser of approved pharmacy reimbursement methods, e.g.:
    1. Average Wholesale Price (AWP) minus % + Dispensing Fee
    2. Federal Maximum Allowable Cost (MAC) (CMS Upper Limit + Dispensing Fee)
    3. Usual and customary charges to the general public
    4. State MAC (State MAC + Dispensing Fee)

    See the MaineCare Benefits Manual @ http://www.maine.gov/sos/cec/rules/10/ch101.htm, Section 80, Pharmacy Services regulations for all payment, co-payment and dispensing fee information.

q. The PBM must process electronic adjustments of paid claims submitted through the Pharmacy POS system.
r. The POS must process online reversals and re-bills and allows the pharmacy up to ninety (90) days to respond and process.
s. The POS must utilize data elements and algorithms to compute claim reimbursement for claims that are consistent with 42 C.F.R. Part 447.
t. The POS must check claims against State-defined service limitations.
u. The POS must edit claims to ensure that all required attachments, per the reference records or edits, have been received and maintained for audit purposes or have been submitted prior to the claim and prior authorization has been established.
v. The POS must deduct MaineCare member co-payment amounts, as appropriate, when pricing claims.
w. The POS must deduct TPL amounts, as appropriate, when pricing claims.
x. The POS must verify that the claim is for services covered by Maine's Medicaid State Plan.

y. The POS must verify that all data necessary for legal requirements are retained. Legal requirements are those detailed in the False Claims Act which include but are not limited to the following;
    1. Inappropriate billing practices
    2. Knowingly shorting prescription drugs
    3. Prescription forging, altering of prescriptions, and dispensing after prescription expired
    4. Adulterated prescription drugs
    5. Illegal payment schemes to pharmacies

z. The POS must track claims flagged for investigative follow-up because of third party discrepancies.

aa. The POS must generate audit trails for all claims. The POS must maintain audit trail history for a minimum of five (5) years.

bb. The POS must verify that all claims for services approved or disallowed are properly flagged as paid or denied.

cc. The POS must control, track, and reconcile captured claims to validate that all claims received are processed.

dd. The POS must verify that claim correction activities have entered only valid override code(s) or manual prices.

ee. The POS must provide and perform municipal general assistance claims processing functions. These include the following:

    1. Accept on-line claims for data capture and price verification as specified by OMS.
    2. Report monthly to participating municipalities in order to verify monies owed to pharmacy providers.
    3. Provide help desk support for municipalities, pharmacies and recipients.

    Successful Bidder's POS shall comply with the State Policy: 10-144 Department of Health and Human Services, Chapter 323: Maine General Assistance Policy Manual.

ff. The POS must be available twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year and 366 days per year during a leap year.

gg. The POS data will be owned by the Department, safeguarded and protected by the PBM and returned to the Department in electronic or other format of the Department's choice.

hh. The PBM must be able to process all POS pharmacy claims within nine (9) seconds, including PRO-DUR review. Processing time is measured from the point that the transaction is transmitted to the point the response is received. On average 1.3 million claims are processed per quarter.

ii. The POS must verify that all providers are actively enrolled in MaineCare.

jj. The POS must maintain a current list of DEA numbers, including business activity code and business activity subcode.

3. The POS must verify authorization for services that require prior approval in order to manage costs or ensure patient safety at a minimum this is to be accomplished by implementing the following;

    a. The POS must interface with the pharmacy prior authorization database.
    b. The POS must interface with the Prior Authorization (PA) system so that prior authorization numbers may be automatically loaded into the POS so they do not have to be manually entered.
    c. The POS must demonstrate that there is a field for authorization or identification when an override indicator (force code) is used.
    d. The POS must interface with electronic authorization of health care service transactions required by 45 C.F.R. Part 162, as follows:

        1. Retail pharmacy drug referral certification and authorization.

e. The POS must perform edits to ensure that a PA is present when required.
f. The POS must notify the submitter when required PA is missing.
g. The POS must enable the PA staff to send requests for additional information on paper or electronically.
h. The POS must process and retain all PA request data for a minimum of seven (7) years.
i. The PA system must be compliant with State and Federal regulations. The PBM must provide a PA system that is automated and user friendly to providers. The PA system must provide member enrollment and eligibility data and MaineCare PDL information to the prescriber at the point of care. This should also allow the MaineCare provider to see the member's prescription history. More specifically the PA system must meet the following;

    1. The PA system must be flexible to allow for changes/updates as requested by the Department.
    2. The PA system must verify client eligibility, pharmacy eligibility, prescriber eligibility and NDC eligibility.
    3. The PA system must verify the PA request form for completeness.
    4. The PA system must have secured fax back and online capability for incomplete forms and for required additional information.
    5. The PA system must research and validate PA criteria rules including research of patient profiles for drug and medical history.
    6. The PA system must send notification of PA determination to MaineCare member, prescriber and pharmacy by secure fax where available and/or mail. The PA system must send Notification to claims processing system for claim adjudication and validation.
    7. The PA system must receive a PA request via mail, web portal or fax (bidders shall provide as much detail as possible when describing what your system can provide; this information to be attached as Appendix G 4 Web PA/Preferred Drug List Portal).
    8. The PA system must process all PA's within twenty-four (24) hours from receipt of completed PA form to PA determination – approved, denied, deferred and no PA required. Electronic tracking is required to verify turnaround time. This performance measure will be monitored via report from the PBM.
    9. The PA system must archive all PA forms and determination date and supporting documentation when applicable in read-only media for a minimum period of seven (7) years. This information must be made available to the Department in case of audit or hearing.
    10. Helpdesk support is required for prescribers and pharmacists for assistance, education and status of PA's in process.
    11. PA's that require manual review will be seen by a pharmacist. Manual review may be required based on PDL criteria.
    12. The PA process outlined in Chapter I of the MaineCare Benefits Manual for deferrals and Section 80 will be followed as well as the Department's requirements.

j. PA Exemption:
The Department has the discretion to exempt providers and/or MaineCare members from PA requirements. The Department may discontinue these PA compliance exemptions any time with written notice to the provider and/or MaineCare member in accordance with policy of the MaineCare Benefits Manual, Chapter II, Section 80 Policies and Procedures (http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s080.docx).
The PBM will notify prescribers of their PA exemptions. This will also include a monthly and

quarterly report to the Department and will show a percentage of providers that are exempt as well as percentage of drug categories.

k. In addition to an automated PA solution the Department requires an E-Prescribing solution that will work with the PA and POS. These functions shall expand as the Department expands health information technology (HIT). There shall be no charge to providers for use of the system. The cost shall be contained in the fixed price given by the Bidder.

4. The POS must verify that services are medically appropriate as set forth below and that they conform to all applicable Center for Medicare & Medicaid Services (CMS) and MaineCare policies.

a. The POS must provide an automated, integrated online real-time PRO-DUR system or provide assistance to the pharmacist to do a prospective drug utilization review.

b. The Department requires a fully automated PRO-DUR system which meets the Code of Federal Regulations (CFR) § 456.716 found at http://www.gpo.gov/fdsys/pkg/CFR-2009-title42-vol4/pdf/CFR-2009-title42-vol4-sec456-716.pdf . At a minimum MaineCare requires the following PRO-DUR functions.

1. The PBM must compile data and produce reports to demonstrate the cost-effectiveness of the PRO-DUR component of the Maine Point of Purchase (MEPOP) system.
2. The PBM must have the ability to easily and quickly add, change or delete edits.
3. The PBM must produce reports that identify provider override of PRO-DUR alert conditions.
4. The PBM must provide an ability to easily and quickly construct and/or change provider messages.
5. The PBM must identify patterns in use and cost by providing drug use profiles by MaineCare member and/or provider. The PBM must provide the Department with online access to the information.
6. The PBM must provide prior authorization forms electronically (via fax).
7. The PBM must provide the Department online access to information on the recipient, diagnosis, provider, and prescription.
8. The PBM must control the production of profiles based on the category of disease, drug class, or other parameters.
9. The PBM must provide an audit trail of inquiries including who made the inquiry, the information input and the response provided.
10. The PBM must generate management level reports on drug utilization.
11. The PBM must eliminate unnecessary and /or inappropriate use of drugs.
12. The PBM must identify possible inappropriate drug therapy patterns prior to dispensing of drugs.
13. The PBM must develop and/or maintain therapeutic class criteria to reduce the incidence of drug therapy failure and drug-induced illness.
14. The PBM must provide inquiring providers online access to information on drug therapies by specific drugs relative to high-risk disease.
15. The PBM must provide inquiring providers online access to information on drug regimens by therapeutic classes of drugs.
16. The PBM must identify problems associated with inappropriate drug use.

c. The PBM must provide a prospective and concurrent review of prescription practices at the pharmacy level and Member level including utilization of the Prescription Monitoring Program (PMP).

d. The PBM must compare each claim against member history, PMP information and benefit rules to determine if the new claim complies with State standards for:

1. Therapeutic appropriateness
2. Over utilization
3. Under utilization
4. Appropriate use of generic products
5. Therapeutic duplication
6. Drug-disease contraindications
7. Drug-pregnancy contraindications
8. Drug-drug interactions
9. Incorrect drug dosage or duration of drug treatment
10. Clinical abuse or misuse
11. Consistency with patient age
12. Consistency with patient sex
13. Consistency with refill policy
14. Overrides
15. Denied claims

e. The PBM must generate alerts (messages) to pharmacy providers as required by NCPDP standards.
f. The PBM must allow the pharmacy the ability to override an alert in accordance with State and Federal guidelines. Overrides of alerts must be tracked and reported.
g. The PBM must maintain user controlled parameters for all standards and messages.

5. The POS must deny claims for members with third party coverage, including Medicare Part D https://www.medicare.gov/part-d/ or flag for pay-and-chase activity.

a. The POS must deny claims for MaineCare members with appropriate third party coverage, enrollment in Managed Care Organization (MCO), or Medicare Part D assignment. The POS must provide insurance information in the POPS message along with notice of denial of payment.
b. The POS must identify claims appropriate for pay-and-chase function. If the drug is designated as "pay and chase", the POS must process and pay the claim (if it meets all other criteria), and reports the claim for follow-up activities.
c. The POS must identify claims requiring third party payment.
d. The POS must generate automated TPL billing information to providers for MaineCare members with third party coverage.

6. The POS must support other business processes that require pharmacy claims data, e.g., drug rebate invoicing, retrospective DUR, and decision support.

a. The POS must flag claims for Drug Rebate processing.
b. The POS must prepare extracts of pharmacy claims history required by the drug manufacturer rebate process. Claims must include all NDC and other data needed to support the rebate process, as follows:

1. Period of time covered
2. NDC number
3. Total units paid
4. Product names
5. Third Party payment information
6. Number of prescriptions paid
7. Rebate amount per unit based on the CMS approved formula

Note: The PBM must submit an extract file to Data Niche to verify utilization. Adjudicated claims are transmitted to the MMIS system. The Department will process invoices for rebates internally.

c. The POS must prepare extracts for pharmacy claims history (or access to the claims history) for purposes of retrospective DUR, prescriber and pharmacy provider profiling, management reporting, and other decision support functions. The PBM will provide data to the MMIS system and will be required to prepare these reports for management as needed, in the determination of the Department.
d. The Department requires a fully functional Retrospective Drug Utilization Review (Retro-DUR) program that meets Federal DUR regulations.

The inputs to the Retro-DUR function of the POPS include:

1. DUR criteria and standards adopted by the Maine DUR Board based on the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), or subsequent requirements;
2. Claims history data;
3. Provider data;
4. Reference data;
5. DUR reporting parameters; and
6. Inquiries and response comments from providers.

The Retro-DUR component must have the following capabilities:

1. Cardiovascular disease;
2. Cerebrovascular disease;
3. Central nervous system disease;
4. Renal disease;
5. Endocrine disease;
6. Gastrointestinal disease; and
7. Psychiatric disease;

The PBM must provide inquiring providers online access to information on drug regimens by therapeutic classes of drugs.

The PBM shall present Retro-DUR data to providers to support their ability to immediately and accurately counsel individuals regarding potential problems associated with drug use. This counseling will be done by implementing a Pharmacy Care Management Program (PCMP) that includes reports and education to the DUR.

The PBM reports must identify patterns in utilization and cost by providing drug profiles with the following information:

1. Member name and ID;
2. Member age and sex;
3. Nursing home ID;
4. Inpatient diagnosis codes;
5. Outpatient/ambulatory diagnosis codes;
6. Dates of service;
7. Provider number;
8. Provider type code;
9. Prescriber code;

10. Drug code and description;
11. Drug strength;
12. Dosage form;
13. Quantity dispensed;
14. Brand certification;
15. Days' supply; and
16. Prescription number.

The PBM must maintain a set of parameters to control the production of profiles based on category of disease, drug class, or other parameters.

7. The PBM is required to implement a PCMP that shall include:
    a. A method to determine annual cost required to participate in PCMP
    b. Number and names of chronic diseases required to participate in PCMP.
    c. Number and type of covered drugs required to participate in PCMP.
    d. Type, frequency and target of interventions

    The PCMP shall provide increased management of high-cost drugs, high-cost pharmacy users, and high volume usage (top twenty (20) drugs prescribed by volume) that have the potential to increase MaineCare's pharmacy spend.

    The PCMP shall provide an individual work plan for each clinical intervention proposed. The work plan shall include a description of the intervention and the objectives to be achieved by the intervention, a summary of the tailored cost avoidance methodology that will be used to track the impact of the intervention and a timeline for the activities under that intervention.

    The primary deliverable associated with this PCMP will be a quarterly report that details the status of the individual clinical interactions, fiscal impact-to-date that includes a year to date estimated cost avoidance as a result of the interventions and an overall project status to be delivered fifteen (15) days after the close of the quarter.

    Individual intervention cost avoidance results will be reported by comparing the cost without intervention (using either FDA approved metrics of duration and dose, when available, or by using time averaged utilization metrics if such FDA information is not available) to the abatement generated by the intervention. Additionally, cost abatement may also be measured by comparing pharmacy and/or aggregate healthcare utilization costs post-intervention to pre-intervention over a specified period (the period chosen will depend on what is clinically relevant based on the intervention performed) utilizing generally accepted techniques.

8. The PBM must provide data to support the Department in case of a drug manufacturer dispute over the rebate invoice.

9. The POS must control access to PBM and data as listed below:

    a. The POS must verify the identity of all users and must deny access to invalid users. Security shall include the following qualities, at a minimum:

        1. Requires unique sign-on (ID and password);
        2. Requires authentication of the receiving entity prior to a system initiated session, such as transmitting responses to eligibility inquires; and
        3. Meets the Department's HIPAA security policy.

b. The PBM must enforce password policies for length, character requirements, and updates. The PBM must require a strong password that includes eight (8) digits with alpha numeric and symbol characters. Passwords must expire every ninety (90) days, requiring a new strong password.
c. The PBM must support a user security profile that controls user access rights to data categories and system functions.
d. The PBM must permit supervisors or other designated officials to set and modify user security access profile.
e. The PBM must include written procedures for the protection of electronic Protected Health Information (ePHI) in the event of an emergency and must provide continuation of protection of ePHI during emergency operations.
f. The PBM must support workforce security awareness through such methods as security reminders (at log on or screen access), training reminders, online training capabilities, and/or training tracking.
g. The PBM must contain a data classification schema with data items flagged to link them to a classification category. The PBM must have an access privilege scheme for each user that limits the user's access to one or more data classification categories based on job need.
h. The PBM must alert its Privacy and Security Officers and the Department of potential violations of privacy safeguards, such as inappropriate access to confidential information.
i. The PBM must contain a data definition for the Designated Record Set (DRS) that can be included in responses to inquiries and report requests.
j. The PBM must support data integrity through system controls for software program changes and promotion to production.

10. The POS system must protect the confidentiality and integrity of ePHI

a. The POS must contain verification mechanisms that are capable of authenticating authority as well as identify the use or disclosure requested. The following are examples:

    1. Denies general practitioner inquiry for recipient eligibility for mental health services.
    2. Permits inquiries on claim status only for claims submitted by the inquiring provider.

b. The POS must support encryption and decryption of stored ePHI or an equivalent alternative protection mechanism.
c. The POS must support encryption of ePHI that is being transmitted, in accordance with HIPAA policy
d. The POS must support integrity controls to guarantee that transmitted ePHI is not improperly modified without detection (e.g., provide secure claims transmission).
e. The POS must provide data integrity of ePHI by preventing and detecting improper alteration or destruction (e.g., double keying, message authentication, digital signature, check sums etc.).

11. The PBM must monitor system activity and act on security incidents.

a. The PBM must provide the capability that all system activity can be traced to a specific user.
b. The PBM must generate alerts for conditions that violate security rules. The following alerts must be incorporated:

    1. Attempts to access unauthorized data and system functions.
    2. Logon attempts that exceed the maximum allowed.
    3. Termination of authorized sessions after a specified time of no activity.

c. The PBM must log and examine system activity in accordance with HIPAA. All users must be approved and logged, and user activity must be monitored to ensure users are accessing only the information that they need to do their work.
d. The PBM must provide security incident reporting and mitigation mechanisms, such as:

    1. Generation of warnings or reports on system activity based on security parameters.
    2. Termination of access and/or generation of reports when potential security violation detected.
    3. Preservation and reporting of specified audit data when potential security violations are detected.

e. The PBM must incorporate procedures for guarding, monitoring, and detecting malicious software (e.g., viruses, worms, malicious code, etc.).

12. The PBM must protect member information and provide member information in accordance with HIPAA privacy regulations. This shall include items a. through d. below.

    a. Respond to an authorized request to provide a report containing the DRS for a given individual.
    b. Contains indicators that can be set to restrict distribution of ePHI in situations where it would normally be distributed.
    c. Tracks disclosures of ePHI; provides authorized users access to and reports on the disclosures.
    d. Has the capability to identify and note amendments to the DRS for a given individual.

13. State specific requirements.

    a. The PBM shall transmit adjudicated claims to the MIHMS system. Data transmitted to the data hub must conform to ACSII txt delimited file and be transferred on the Department's specified FTP server.

       The PBM shall retrieve eligibility feeds from MIHMS. This data includes demographics, eligibility and TPL information.

    b. Clinical and data analyst:

       The PBM must be required to participate in groups to be identified by the Department, such as Academic Detailing and Supplemental Rebate review as needed throughout the term of the contract to offer data, analysis of data, clinical review and support to the Department. Clinical review must include a pharmacist or physician.

    c. The PBM must provide quarterly education seminars throughout the State to providers in order to educate prescribers on how to navigate the PDL. The PBM must explain use of the web and PA system so provider staff can eliminate PA paperwork.

       The PBM must submit to the Department an annual work plan. The work plan must include planned outreach and education sessions. These sessions can be conducted in person one-on-one or with large groups or through a webinar program. There must be four (4) planned sessions per year.

    d. The PBM will be responsible for a full SSAE16 SOC 2 Type 2 annual audit. A copy of the audit will be provided to the Department's Project Manager.

e. The PBM will provide information to the Department in order to assist management in fiscal planning and control.

f. The PBM will provide information necessary to the Department for the review and development of pharmacy policy and regulations.

g. The PBM must conduct an annual HIPAA risk assessment. This assessment must be provided to the Department.

h. The PBM will provide to the Department counts of services based on meaningful units such as but not limited to:

    1. Service category (e.g., days, visits, units, prescriptions);
    2. Unduplicated claims;
    3. Unduplicated beneficiaries; and
    4. Unduplicated providers.

i. The PBM will support online real time summary information such as, but not limited to, number and type of providers, MaineCare members and services.
j. The PBM will provide the capability to produce unduplicated counts within a type of service and in total by month.
k. The PBM will assist in determining reimbursement methodologies by providing expenditure data by the National Drug Code (NDC).
l. The PBM must retain all information necessary to support State and Federal initiative reporting requirements.
m. The PBM must provide information such as, but not limited to, paid amounts, outstanding amounts and adjustment amounts to be used for analysis of timely reimbursement to the Department.
n. The PBM must conduct and provide to the Department analyses of data on individual drug usage.
o. The PBM must maintain providers' NPI, Drug Enforcement Administration (DEA) number(s) and X-DEA number(s).
p. Medicare Part D participation:

    1. The PBM must assist members with enrollment into state contracted plans by reviewing the Member's eligibility, drug history and demographics and enrolling them into a State contracted plan that fits their individual needs. An enrollment file will be created and submitted by the PBM in a timely manner to the Part D plans.

    2. The PBM must participate in the review of Part D plan annual proposal. This will include review of the formularies and an analysis of the step therapy, quantity limits and PA.

    3. The PBM must exchange monthly reports with the Medicare Part D Plans (PDP's.) These include enrollment, invoices, remittance, Prescription Drug Event (PDE) and updates to formulary files.

    4. The PBM must review each member on the invoice for payment to be determined based on established business rules. The PBM must generate a remittance advice detail report for the PDP's review of each member and a summary sheet describing payment.

5. The PBM will receive PDE files that they must check for accuracy and analyze for fraud and abuse. The PBM must generate and submit a quarterly report to the Department.

6. The PBM will receive PCMP reports from plans and must clinically review and analyze to create a summary for Department staff.

7. The PBM must incorporate benefit levels for different populations within the POS to accommodate the Medicare Part D program to include maintenance of Part D covered drug data.

8. The PBM must operate and maintain collaborative data feeds with different agencies to obtain various data elements such as RAC (Recipient Aid Category) codes, LIS indicators, and living arrangement codes not previously available to set up the Part D account. This includes processing of the Medicare Prescription Drug Improvement and Modernization Act (MMA) and State Pharmacy Assistance Program (SPAP) files.

9. The PBM must support Medicare Part D Annual Enrollment and related changes, including:

    a. Creation of a "carve out" file for CMS;
    b. Creation of a Top 500 Drug list for annual PDP RFP process;
    c. Providing clinical evaluation of formularies and plans. The PBM will advise the Department about those plans but will not be involved with the scoring of the RFP~~;~~
    d. Modeling annual enrollment volumes;
    e. Updating list of contracted PDPs and related impacts to PDP Premium Invoicing;
    f. Updating POS programing (e.g. deductibles, co-pays, gap threshold and maximum, etc.);
    g. Adjusting data imports and extracts, as needed, from / to PDPs and CMS;
    h. Adjusting eligible Member selection business rules, if needed, for both annual and monthly IRA processes; and
    i. Establishment or termination of secure FTP processes, as required.

14. The PBM must have Clinical Support Staff available to Department staff. The PBM staff must include pharmacist and physicians able to assist in making decisions for the budget, policy, and clinical appearance at Administrative Hearings. The PBM must give high priority to responding to requests for budget or legislature information. Clinical support staff must provide clinical and data analytics in order to respond to the Department within twenty-four (24) hours of the request.

15. The PBM must be able to accept and collect the Average Manufacture Price (AMP) data quarterly and accept the Best Price files from manufacturers through a website portal. The PBM must be able to accept electronic signatures verifying data. The PBM must store data and be ready to review information as needed and provide clinical expertise for a variety of occasional projects.

16. The PBM must have a pharmacy help desk available to providers for clinical and technical support required to be staffed from 8 am – 9 p.m. Monday through Friday and 8 a.m. – 6 p.m. on Saturday and Sunday. After 5 p.m. on weekdays and weekends, the PBM's pharmacy help desk must assist MaineCare members with questions and helping them to receive their medications. During the Department's normal business hours from 8 a.m. – 5 p.m., the Department handles Member inquires.

17. The PBM must participate in State and Federal audits as required. Participation may include but is not limited to providing reports, claims history and an overview of the claims process. Reports must be completed within five (5) business days from the date of the request.

18. The PBM must complete and deliver ad hoc reporting requested by the Department within five (5) business days of receipt of the request.

19. The PBM must provide a tool for the Department's member pharmacy helpdesk staff that will allow them to look up Member pharmacy history and research current status to include Part D enrollment information and eligibility. A minimum of fifteen (15) Department staff members will need access.

20. The PBM must provide a reporting tool that will allow the Department's pharmacy staff to query on pharmacy items such as claims, Part D history enrollment and premium payments, PDL queries, and Member-specific queries. A minimum of fifteen (15) Department staff members will need access.

21. Preferred Drug List (PDL) Management:

    The PBM shall be responsible for:

    a. Maintaining the PDL and related systems and databases to minimize PAs and assist the Department to manage pharmacy and physician resistance.
    b. Avoiding unnecessary PAs, the claims processor shall look back for preferred drug trials of a specified duration within a specified timeframe in order to determine access to a non-preferred drug based on the failure of one (1) or two (2) preferred drugs.
    c. A claims processing system that must enforce step-care requirements.
    d. A predictive pricing approach to estimate the final budget impact of PDL decisions after accounting for all rebates, prescribing alterations, and offsetting administrative costs and provide quarterly analysis of implemented savings and re-estimation of future savings against targets.
    e. Clinical and pharmaceutical staff that shall provide a high-level analysis to determine the safety and efficacy of drugs within targeted therapy classes.
    f. Maintaining the drug placement on the PDL at the request of the State and/or Drug Utilization Review (DUR) Committee.
    g. Providing on-going clinical analyses and maintenance of the PDL, including:
        1. When drugs become unavailable due to shortages or discontinuation.
        2. When new products and new forms enter the market
        3. When generics become available but are not financially attractive due to costs as compared to brands with significant rebates
        4. When new FDA approved indications require revisions of existing criteria.
        5. When warnings are released on drugs.
        6. When price fluctuations occur on preferred drugs.
        7. When companies submit supplemental rebate offers late and negotiations must be restarted.
        8. Supporting and maintaining the ePocrates formulary library.
        9. Supporting and maintaining multiple PDLs for MaineCare and Drugs for the Elderly.

22. State Maximum Allowable Cost (SMAC)

    a. The PBM shall be responsible for managing the SMAC. The PBM shall conduct the following tasks;

        1. Monthly analysis of generic drug pricing;
        2. Identification of new drugs that can be placed on the SMAC list;
        3. Looking for established generic drugs to reduce SMAC price;
        4. Review complaint resolutions related to pharmacies' questioning whether a

SMAC price is too low;

5. Review SMAC changes for impacts to the PDL, possibly changing the PDL as a result;
6. Calculate estimated savings based on SMAC efforts;
7. Review pharmacy concerns related to SMAC pricing. The PBM must gather information to compare pharmacy's reported acquisition cost to other pharmacy acquisition costs;
8. Review monthly any generic drugs with significant volumes (at least $1,000 worth of activity) that have increased or decreased substantially in cost (greater than 10%), selected for review by the State's Pharmacy Manager and SMAC is readjusted;
9. Review new generic drug SMAC candidates that are identified by comparing CMS rebates to paid amounts and used in creating a new SMAC price;
10. After new SMACs are created or readjusted, re-examine the PDL A new SMAC may allow a non-preferred generic drug to be re-designated as preferred;
11. Post proposed SMACs to the maincarepdl.org website seventeen (17) days prior to implementation to allow for pharmacy review and dispute;
12. Submit to the Department all proposed changes to the SMAC list for review and approval prior to implementation;
13. Provide a thorough QA process of implemented SMAC prices to ensure consistent and correct pricing;
14. Provide monthly QA reporting to confirm that SMAC prices on the POS and posted on mainecarepdl.org match the prices intended and approved by the Department; and
15. Ensure that SMACs are effective the last Friday of the month. If requested by a pharmacy, the SMACs' effective date can be set retroactively to the date of the claim that triggered the SMAC adjustment.

23. DUR Committee Support

a. The PBM shall provide staff support for the DUR Committee. This support shall include the following:

1. Develop meeting schedule and agendas;
2. Send meeting schedule and agendas to DUR Committee members;
3. Record and write meeting minutes;
4. Assist the Department in the recruitment of members when vacancies occur;
5. Provide and assist in the presentation of drug monographs to the DUR Committee to assist in achieving rationale assessments as to what drugs represent the best value for MaineCare Members;
6. Solicit information regarding any DUR study preferences that the DUR Committee may have an interest in pursuing;
7. Assist the DUR Committee in assessing which drugs are the best value; this may include advice on PA criteria;
8. Provide supplemental clinical subject matter expertise for the DUR Committee; and
9. Create and provide customized drug monographs to the DUR committee based on committee's specifications.

24. Intensive Benefit Management (IBM)

a. The PBM shall develop and administer an IBM program. The program shall contain the

following components:

1. Identify MaineCare Members who are shopping for prescription drugs by receiving prescriptions for certain drugs from multiple physicians, and/or having prescriptions filled at multiple pharmacies. Once identified, these members shall be enrolled in the IBM program. As part of the IBM, the PBM shall develop a Lock-In Program consistent with MaineCare Benefits Manual, Chapter II, Section 80, Pharmacy Services (http://www.maine.gov/sos/cec/rules/10/ch101.htm) should it be necessary to limit a MaineCare Member to one pharmacy to further minimize potential fraud, waste and abuse.
2. Generate and maintain reports showing physician prescribing and IBM Member use habits. If reports indicate trends of misuse/abuse, the Member involved shall be notified of the behavior. The physicians and pharmacies involved shall be reported to the Program Integrity Unit (PIU);
3. Develop recommendations on resolving a misuse / abuse situation and on preventing further misuse / abuse of the prescription drug and the MaineCare program. Resolutions for physicians and pharmacies will be sent to the PIU.
4. Provide a narcotic user report every quarter and mail to those doctors prescribing to members meeting the criteria for misuse / abuse.
5. Conduct chart reviews and related research to assist PIU through recommendations and consultation, as requested.
6. Report all MaineCare members who receive an IBM letter to PIU.
7. Support Department efforts in identifying patients in need of close narcotic supervision and allow for restricting narcotic prescribing to one (1) or multiple prescribers and / or restriction to one (1) prescriber.

25. Sovereign States Drug Consortium (SSDC)

a. The State of Maine is one (1) of ten (10) states that have joined a consortium to negotiate supplemental rebates above those required by CMS per Maine's Supplemental Rebate Agreement that also meet the requirements of the federal law at Section 1927 of the Social Security Act (42 USC 1396r-8). The other states include Delaware, Iowa, Mississippi, North Dakota, Oregon, Utah, Vermont, West Virginia and Wyoming. The PBM shall provide the following services in support of Maine's participation in the SSDC:

1. Review and assess manufactures rebate proposals;
2. Provide recommendations to the State on which proposals to accept; and
3. Provide information and/or recommendations to the DUR in those cases that are referred to the DUR.

26. Control Matrix

The Control Matrix shall contain the following components:

a. Phone reports that reflect previous month and show month over month and year over year, to include:
    1. Abandoned calls;
    2. Answered calls;
    3. Average length of calls; and
    4. Average hold time.

b. Calls to be broken out per unit PA, technical support, clinical support, and member support.

1. Calls must be answered in an average of thirty (30) seconds or less.
2. Abandoned rate will be less than 5%.

c. Standardized Reports to be provided:

Frequency	**Report**
Weekly	Pay Cycle Report By Medicaid Recipient Aid Program Code
	Pay Cycle Report, Programs Combined with Comparison
	Pay Cycle User Report Combined with Comparison
	Pay Cycle Report POS Current Fiscal Year
	Pay Cycle User Report POS
	Pay Cycle Report Medicaid only, with Comparison
	Pay Cycle Report Medicaid with Comparison
	Pay Cycle Report State-Only Drugs, with Comparison
	Pay Cycle User Report State-Only Drugs with Comparison
	CAP Report Fiscal Year to Date Patient Co-pay >$500
	Mail Order MaineRx Plus
	Average Generic Script Cost
	$200/prescription activity report
	Weekly Pay Cycle (adjusted total–reflects totals in weekly extract to MIHMS)
	Co-pay cost savings
	Maine Part D Utilization Summary

Frequency	**Report**
Monthly	Point of Sale (POS) Override Summary
	Prior Authorization (PA) Statistics Report by drug name descending volume
	PA statistics report, approval and denial rates by Preferred Drug List (PDL) category
	PA Statistics report, average determination time
	Pay cycle report current fiscal year
	Pay cycle user report with comparison
	Pay cycle report basic drugs current fiscal year
	Pay cycle report supplemental drugs, current fiscal year
	Claims Paid, Denied and total number of claims for Brands and Generics and for Brands and Generics combined.
	Top 10 Drugs by Cost
	Top 10 Drugs by Utilization
	Maine Lock-In/IBM Restriction List – Changes Only
	Cash Waivers Report
	State Maximum Allowable Cost QA Report
	Budget Initiatives Savings Report (based on Maine Legislative laws created to save money).
	Dashboard Report
	Medicare Prescription Drug Improvement and Modernization Act (MMA) and State Pharmacy Assistance Program (SPAP) Eligibility Summary
Frequency	**Report**
Quarterly	Pharmacy Care Management Program Report
	Cash Waivers Report
	Third Party Liability (TPL) Savings Report
	Pharmacy Incentive Program (PIP) Extracts (Summary and Detail)

	Claim Trending Analysis (spike billings)

d. Other measurable reports that will be required on an as needed basis include:
    1. Cost savings report
    2. PDL updates/changes/notifications
    3. Member and provider education

e. PDL updates are to be put in a newsletter monthly. The PBM will send this via fax to all pharmacies and make it available to OMS staff for the purpose of publishing through provider monthly letters.

f. Benefit plan design:
    1. The initial benefit plan design will be loaded into the system by March 01, 2016.

g. Eligibility:
    1. Member eligibility will be loaded by April 01, 2016.

h. Telephone numbers for call centers will be established no later than April 01, 2016.

i. Communication:
    1. PBM's Project Manager will provide a bi-weekly report to the Department's Project Manager that provides the timeline with an indication that the project is on schedule. If not on schedule, than an explanation as to why and how the issue will be rectified.

j. Data systems availability and adjudication:
    1. PBM guarantees an annual average 99% system availability of the point-of-sale adjudication system.

k. PBM will limit the number of planned outages (system availability) during the business week to one (1) time per month.
    1. Downtime for routine maintenance must be approved by the Department.

l. Claim adjudication accuracy rate:
    1. PBM guarantees as calculated: the total number of claims minus the number of claims processed with error, divided by the total number of claims will be greater than 95% measured and reconciled annually.

m. Financial payment adjudication:
    1. PBM guarantees as calculated: the total paid dollars (-) [absolute value of overpayments]/[total paid dollars] will be greater than or equal to 99% measured and reconciled annually.

n. Provider Survey:
    1. PBM guarantees that 90% of survey participants' responses to a question measuring overall satisfaction with the prescription benefit program will indicate "satisfied" or "very satisfied." This standard will be measured and reported annually.

o. Reporting:
    1. PBM guarantees access to online reporting data will be available within an annual average of fifteen (15) days after month-end. Billing data will be available within

an annual average of fifteen (15) days after the billing cycle.

p. Eligibility accuracy:
    1. PBM guarantees that electronic eligibility records will be loaded with 95% accuracy.

q. Pre-Implementation Audit and Readiness Assessment:
    1. PBM will fund a pre-implementation audit and readiness assessment to be conducted by a designee of the Department on behalf of the Department. The purpose of the audit and assessment is to ensure accurate plan setup prior to the "go live" date.

r. Disaster Recover and Business Continuity:
    1. PBM is responsible for system backups. If the system has to be restored, it must be recovered in less than 24 hours or Recovery Time Objective (RTO) with no more than 24 hours of data loss or Recovery Point Objective (RPO).
    2. The PBM is responsible for the Disaster Recovery and Business Continuity plan. A full disaster recovery test is required annually at a minimum.

s. The PBM's proposed solution must comply with ALL relevant policy (www.maine.gov/oit/policies).
These include:
    1. Remote hosting policy. http://www.maine.gov/oit/policies/Remote-Hosting-Policy.htm
    2. Security policies: http://www.maine.gov/oit/policies/index.shtml),
    3. Infrastructure deployment certification policy: http://maine.gov/oit/policies/Application-Deployment-Certification.htm
    4. Application deployment certification policy: http://maine.gov/oit/policies/Infrastructure-Deployment-Certification.htm
    5. Accessibility policy: http://maine.gov/oit/policies/WebAccessibilityUsabilityPolicy.htm

t. Response time required for reported issues must be as follows;
    1. Critical (Application down/unavailable) – Response within 30 minutes.
    2. High (Level 1) - Defect significantly impacting production operations: Level 1 Defects will be resolved as quickly as possible, within 8 standard business hours.
    3. Medium (Level 2) - Defect impacts business operation; however, there is a workaround available
    4. Level 2 Defects will be resolved within the next scheduled upgrade, as determined by Bidder.
    5. Low (Level 3) - Defect does not significantly impact network
    Level 3 Defects will be resolved in a future upgrade, as determined by the successful Bidder

GENERAL REQUIREMENTS – MAINE CENTER FOR DISEASE CONTROL AND PREVENTION

1. REQUIREMENTS – MAINE TUBERCULOSIS (TB) PREVENTION AND CONTROL PROGRAM (TB Program)

A. Overview

The primary activity will be to process pharmaceutical claims for eligible recipients of the TB Program. The objectives and key activities below describe the specific services.

B. Scope of Work

1. Objectives and Key Activities of the Successful Bidder Related to the TB Program:

   a. Manages a geographically diverse network of pharmacies in Maine, including State of Maine pharmacies, private pharmacies, and hospital pharmacies:

      i. Communicates with pharmacies when there are significant program changes, such as drug updates or major changes in how the TB Program interacts with insurance companies or other government payers,
      ii. Provides the TB Program with a list, in electronic format, of pharmacies in the network at the beginning of each agreement year and whenever there are significant changes (more than 10 individual pharmacies or any pharmacy chain).

   b. Successfully adjudicates individual drug claims with a minimum of barriers to the client and in compliance with Maine CDC payer of last resort guidelines.

      i. Has the ability to securely receive the following member eligibility information for all active TB Program members: membership ID, name, date of birth, authorized date, coverage date and coverage group (as described in the table below):

TB Program Coverage Group	Level of Benefit
MC (Medicaid only or Medicaid and private insurance, Medicare Part D)	TB Program pays member's remaining copay up to $10 for formulary drugs
PI (private insurance only)	TB Program pays member's copay up to $20 per 30-day supply for formulary drugs
SA (no insurance)	TB Program pays the full cost (MaineCare rates) of drug for formulary drugs

      ii. Processes member eligibility information on the same business day it is received and maintains a secure data system that is capable of receiving and managing the eligibility information to use for claims processing.
      iii. Pays TB Program Coverage Groups at MaineCare reimbursement rates.
      iv. Processes formulary drugs at the lowest cost to clients. MeCDC reviews the federal TB Program drug reimbursement process and will inform the successful Bidders of any process changes.

v. Provides online claims processing services, including online claims adjudication and split billing through a secure and password-protected electronic claims processing and reporting system that is accessible to the Pharmacy Benefits Manager, TB Program and network pharmacies. The electronic claims system must allow for confidential communications of claims, product cost, and individual prescription history. The successful Bidder will work with TB Program to accomplish any necessary data transfers. Access to this system is to be determined by TB Program and administered by the successful Bidder (i.e. training, user setup, password reset, technical support, etc.).

vi. Allows TB Program staff member access to the Pharmacy Benefits Manager system for TB Program clients.

vii. Monitors billings to assure non-duplication, proper benefit staging and proper split between payers to ensure that TB Program is payer of last resort.

viii. Processes reversals and rebillings for any claims processed improperly.

ix. Coordinates payment to pharmacies for prescriptions they fill and submits invoices to TB Program for payment twice per month. Invoices will include all fees and costs for claims processed during that period. Invoices will include summary data that reconcile totals from claims data with any adjustments.

x. Ensures that claims are paid only for members who are active with the TB Program and for drugs listed on the Formulary at the time the prescription is filled.

xi. Processes Prior Authorizations as required by the Formulary in the second year of the contract.

xii. Allows for special overrides for prescription coverage and rates, with use of non-medical Prior Authorization requests from the TB Program for clients with private insurance who have high deductibles or catastrophic copays.

xiii. Allows for coverage of one month supplies of drugs. The drug treatment timeline follows physician prescription.

xiv. Ensures that members and/or PHN staff are able to obtain 14-day supply of drugs even when they are not able to present a TB Program authorization number at the pharmacy.

xv. Allows PHN staff to pick up 30 days of TB medication with proper TB Program authorization number from pharmacies.

c. Complies with all required reporting and submits required reports on time.

i. Engages in data sharing with the Centers for Medicare & Medicaid Services (CMS) and Medicare Prescription Drug Plans (PDPs)

ii. Provides TB Program with line-listed claims data (including reversals) by the 15th of every month for the prior month. These data must be formatted for import into the TB data system for reporting and must be transmitted via secure web-based data transfer. See Appendix D ("TB Data Import Specifications") for details about the information to be transmitted and how it must be formatted. Note that as reporting requirements or data system changes occur, these import specifications may also change.

iii. Provides the TB Program with the following reports for the prior month's activities by the 15th of each month: a report of prior authorizations and overrides that details the date, the drug, the amount paid, the prior authorization number and the member's TB coverage group and membership ID; and an adherence report in an editable format (preferably Microsoft Excel), that details members who have picked up drugs early, late or who did not show up to get their drugs and which includes TB membership ID, drug, date of prescription/refill, number of days supplied, pharmacy and prescriber.

d. Provides timely and successful troubleshooting and resolution of billing issues at the pharmacy level.

i. Provides capable technical help desk staff to address eligibility and pharmacy issues related to claims processing and billing. Staff must be available by phone and email at least during weekday business hours of 8:00 a.m. to 5:00 p.m. ET. Typical support functions will include receiving member eligibility instructions from the TB Program concerning new and continuing members, assisting with coordination of benefits questions from TB Program and from pharmacies and troubleshooting for members having problems obtaining their drugs at the pharmacy.

e. Holds data strictly confidential.

i. Provides the TB Program with a copy of its confidentiality policy to demonstrate high standards of data security and confidentiality. All staff with access to TB Program data will be required to sign a confidentiality agreement on an annual basis. TB Program member information may not be used for commercial purposes.

f. Completes a successful implementation of the program.

i. Provides a written estimate of cost for any electronic systems upgrades prior to initiating such upgrades, and informs the TB Program when the Bidder has reached 75% of the cost estimate in the event that the successful Bidder anticipates a greater cost.

ii. Manages the Formulary as defined by the TB Program. The formulary includes individual drugs and whole classes of drugs. The TB Program will occasionally request the addition of specific drugs to the formulary. The TB program may choose not to add individual drugs to the formulary or to require prior authorization for various reasons. The successful Bidder will be responsible for costs incurred for any drugs the successful Bidder adds to the formulary in error. The successful Bidder will send an electronic copy of the formulary to the TB Program every quarter along with a summary of changes from the previous quarter.

iii. Meets with TB staff to resolve technical or contractual problems that may occur during the term of the resulting contract or to discuss the progress made in the performance of obligations, at no additional cost to the TB Program. Meetings will occur as problems arise and will be coordinated by the TB Program. The successful Bidder will be given a minimum of three working days' notice of meeting date, time, and location. Face-to-face meetings are desired. However, at the successful Bidder's option and expense, a conference call meeting may be substituted. Consistent failure to participate in problem resolution meetings, failure to make a good faith effort to resolve problems, or two consecutive missed or rescheduled meetings may result in termination of the contract.

C. Reporting

1. Reports and Data Required for the TB Program:

a. Monthly Usage – line-listed claims data (including reversals) formatted for import into the TB Program's data system for annual federal reporting and transmitted via secure web-based data transfer.

a. Due the 15th of the following month.

b. See Appendix D ("TB Data Import Specifications") for details about the information to be transmitted and how it must be formatted.

b. Monthly Prior Authorizations and Overrides –the date, the drug, the amount paid, the prior authorization number and the member's TB coverage group and membership ID.
   a. Due the 15th of the following month.
   b. The Department has no specific preference for format as long as all required data elements are included.

c. Monthly TB Adherence Report – identification of members who have picked up drugs early, late or who did not show up to get their drugs, TB Program membership ID, drug, date of prescription/refill, number of days supplied, pharmacy and prescriber.
   a. Due the 15th of the following month.
   b. Delivered in an editable format (preferably Microsoft Excel).

d. Quarterly TB Program Formulary Report – identification of all drugs currently covered by the TB Program by drug class and drug name; a product description, including whether the drug is a brand or generic; effective date the drug was added to the Formulary; date drug was removed from the Formulary (if applicable); and indicating if a Prior Authorization is required.
   a. Due 15 days after the close of each quarter.
   b. The Department has no specific preference for format as long as all required data elements are included.

e. Additional periodic reports as requested by the TB Program for an additional fee. The fee shall be negotiated at the time of the request for the additional report based upon the estimate of time to create, test, and produce the report.
   a. Bidders should propose any additional standard reports which could assist the program

2. REQUIREMENTS – PARTNERSHIP FOR A TOBACCO FREE MAINE PROGRAM (PTM)

A. Overview

PTM is seeking proposals that utilize either the pharmacy system or a mail order system or a combination of the two. A complete description of the Bidder's distribution system must be addressed in the proposal using one of the following approaches:

1. Respond to standardized electronic and fax requests from the MTHL by contacting the designated pharmacy and arranging for pickup of an over-the-counter NRT by eligible clients. Pharmacies will file the claim on their system using the authorization code provided by the PBM. The PBM establishes contracts with participating pharmacies, provides and updates a list of participating pharmacies, processes and pays the pharmacy claim, serves as the fiscal intermediary for PTM and reports to PTM as required.

OR

2. Respond to standardized electronic and fax referrals from the MTHL by mailing the requested medication directly to the client, ensuring delivery within two to three days.

The PBM will submit an itemized bill to PTM on a monthly basis that includes reimbursement for drugs as well as management fees.

B. Procedures

MTHL counselors initially authorize two weeks of NRT for eligible callers and can provide up to two months of therapy overall. Subsequent authorizations, or refills (typically another two-week and a four-week authorization), require follow-up contact with the MTHL. NRT users are educated about proper medication use during the initial call and side effects or problems are reviewed during subsequent calls.

Once the MTHL has all the necessary patient information, voucher is sent to the PBM indicating the type and quantity of NRT required, as well as information on the preferred pharmacy. Currently, the MTHL electronically submits identifying data and medication information for each eligible caller to the PBM. The PBM will contact the MTHL, when necessary, to verify information contained on the voucher. Upon receipt of all necessary information, the PBM will create a prior authorization and assign a prior authorization number so that the voucher content may be retrieved later. The PBM will contact the pharmacy to provide the assigned prior authorization number and to assist in processing the claim. The recipients will only need to identify themselves at the pharmacy for pickup of the medication. Recipients must contact an MTHL counselor prior to being eligible to receive a refill. Upon counselor approval and receipt of a second voucher, the PBM will contact the pharmacy to assist in processing the claim in the same manner described above.

This service includes invoicing the Maine CDC, depositing monies for reimbursement in a designated account, sending remittance reports to the pharmacies, cutting reimbursement checks to the pharmacies and reporting to the Department. MTHL counselors will initially handle refill requests and, upon counselor approval, the PBM will process the refill claim. Refills are handled in the same manner as an initial request.

C. PTM eligibility requirements

PTM eligibility requirements for NRT state that a tobacco user is eligible if he or she: 1) is ready to quit in the next 30 days 2) is age 18 or older, 3) is not pregnant or planning pregnancy and 4) does not have health insurance or insurance benefits for pharmacotherapy. (Callers identified as MaineCare beneficiaries have access to NRT with a prescription and thus are not routinely eligible for a voucher through the MTHL). Clinical decision-making about the type and dose of NRT is based upon recipient preferences, amount of tobacco use, quit history and medical conditions. Counselors screen for exclusions, including pregnancy or planning pregnancy, less than 18 years of age, unstable cardiac disorder or worsening angina in the last six months, or previous serious reaction to NRT use.

Once the MTHL counselor identifies a caller as appropriate for medication treatment and determines an individual plan for the recipient, the PBM will receive a call or fax and information to initiate a claim. This information will include:

i. Recipient name
ii. Address

iii. Telephone number
iv. A unique ID number
v. Drug name and dose
vi. Pharmacy preference
vii. Physician name (if available)

E. Medications

The Maine tobacco treatment medication distribution system is limited to the following non-prescription medications:

i. Nicotine Transdermal Patch
ii. Nicotine Prolacrilex Gum
iii. Nicotine Lozenge (usual and customary dosing – restricted to those eligible tobacco users for whom other forms of NRT are contraindicated)

As noted previously, the dosage and quantity of the NRT provided is determined by the MTHL. Generic forms of the above medications are required to be dispensed unless not available at an authorized pharmacy. The price of the medications must not exceed the rate of average wholesale price (AWP) minus 13%, the usual and customary charges for over the counter requests or the MaineCare rate of payment, whichever rate of the three is the lowest.

F. Anticipated demand for NRT:

Demand for NRT fluctuates over the year and due to factors in the environment. The MTHL use is highly correlated with media activity that helps to motivate people to quit as well as directs them to the MTHL as a quit resource. Volume in State Fiscal Year 2014 was 9,465 vouchers processed.

The MTHL has made steady gains in number of recipients treated since its beginning in 2001. In State Fiscal Year 2015, the MTHL received 15,294 calls. The MTHL in recent years has served three to four percent of tobacco users in the State per year.

G. Data Collection and Reporting

The successful Bidder shall report utilization directly to the PTM and comply with all the Department/PTM requirements for reporting including, but not limited to:

i. individuals using each type of medication (monthly and YTD)
ii. # of medications distributed, by drug type and dose (monthly and YTD)
iii. # of refills by medications distributed, by drug type and dose (monthly and YTD)
iv. # of persons with monotherapy and # with combination therapy (monthly and YTD)
v. average cost per script and per user
vi. other reports as required by the State
vii. monthly invoices to the PTM

Each report will include monthly totals, YTD and a comparison with the same month in the previous year. The PBM will provide a detailed definition of each category reported, including the method using for calculating average cost per recipient.

Reports are due within 14 calendar days after the close of each reporting period.

H. Program Management

The successful Bidder will meet with the Department and other contractors for coordination and planning in person or via telephone conferencing approximately once per month. Additional meetings may be negotiated.

3. REQUIREMENTS – MAINE AIDS DRUG ASSISTANCE PROGRAM (ADAP)

A. Objectives and Key Activities of the Successful Bidder Related to ADAP:

1. Manages a geographically diverse network of pharmacies in Maine, including State of Maine pharmacies, private pharmacies, mail order pharmacies and hospital pharmacies.

    a. Communicates with pharmacies when there are significant program changes, such as formulary updates or major changes in how ADAP interacts with insurance companies or other government payers.

    b. Provides ADAP with a list, in electronic format, of pharmacies in the network at the beginning of each agreement year and whenever there are significant changes (more than 10 individual pharmacies or any pharmacy chain).

2. Successfully adjudicates individual drug claims with a minimum of barriers to the client and in compliance with Federal payer of last resort guidelines.

    a. Has the ability to securely receive the following member eligibility information for all active ADAP members: membership ID, name, date of birth, authorized date, coverage termination date and coverage group (as described in the table below):

ADAP Coverage Group	Level of Benefit
MC (Medicaid only or Medicaid and private insurance)	ADAP pays member's remaining copay up to $10 for formulary drugs
DU (Medicaid and Medicare Part D or Medicaid, Medicare Part D, and private insurance)	ADAP pays member's remaining copay up to $5 for formulary drugs
MD (Medicare Part D only or Medicare Part D and private insurance)	ADAP pays member's share of cost, including full cost of drugs in donut hole, for formulary drugs
PI (private insurance only)	ADAP pays $20 per 30-day supply for formulary drugs
SA (no insurance)	ADAP pays the full cost of drug for formulary drugs
HE (health exchange plan)	ADAP pays member's share of cost for formulary drugs

b. Processes member eligibility information on the same business day it is received and maintains a secure data system that is capable of receiving and managing the eligibility information to use for claims processing.
c. Provides online claims processing services, including online claims adjudication and split billing through a secure and password-protected electronic claims processing and reporting system that is accessible to the Pharmacy Benefits Manager, ADAP and network pharmacies. The electronic claims system must allow for confidential communications of claims, product cost and individual prescription history. The successful Bidder will work with ADAP to accomplish any necessary data transfers. Access to this system is to be determined by ADAP and administered by the successful Bidder (i.e. training, user setup, password reset, technical support, etc.).
d. Monitors billings to assure non-duplication, proper benefit staging and proper split between payers to ensure that ADAP is payer of last resort.
e. Processes reversals and rebilling for any claims processed improperly.
f. Coordinates payment to pharmacies for prescriptions they fill and submits invoices to ADAP for payment twice per month. Invoices will include all fees and costs for claims processed during that period. Invoices will include summary data that reconcile totals from claims data with any adjustments.
g. Ensures that claims are paid only for members who are active with ADAP and for drugs listed on the Formulary at the time the prescription is filled.
h. Processes Prior Authorizations as required by the Formulary.
i. Allows for special overrides for prescription coverage and rates, with use of non-medical Prior Authorization requests from the ADAP for clients with private insurance who have high deductibles or catastrophic copays.
j. Allows for coverage of three-month supplies of drugs, at a reimbursement cap of three times the monthly rate if approved by primary payers.
k. Creates ADAP membership cards (similar to insurance coverage ID cards) and sends them to members within 10 business days of request. Cards contain specific information that identifies the cardholder, his or her eligibility to receive benefits from ADAP and other information that tells the pharmacist how to contact the Pharmacy Benefits Manager and ADAP.
l. Ensures that members are able to obtain drugs even when they are not able to present an ADAP membership card at the pharmacy.

3. Complies with all required reporting and submits required reports on time.

a. Engages in data sharing with the Centers for Medicare & Medicaid Services (CMS) and Medicare Prescription Drug Plans (PDPs) and manages True Out Of Pocket expense (TrOOP) reporting requirements, as per the *Supplemental Drug Program Data Sharing Agreement*, available at: http://hab.hrsa.gov/manageyourgrant/pinspals/adaptroopltr1011.pdf
b. Provides ADAP with line-listed claims data (including reversals) by the 15th of every month for the prior month. These data must be formatted for import into the ADAP's data system (CAREWare) for annual federal reporting and must be transmitted via secure web-based data transfer. See Appendix H ("ADAP Claims Data Import Specifications") for details about the information to be transmitted and how it must be formatted. Note that as reporting requirements or data system changes occur, these import specifications may also change.
c. Provides ADAP with the following reports for the prior month's activities by the 15th of each month: a report of prior authorizations and overrides that details the date, the drug, the amount paid, the prior authorization number and the member's ADAP coverage group and membership ID; and an adherence report in an editable format (preferably

Microsoft Excel), that details members who have picked up drugs early, late or who did not show up to get their drugs and which includes ADAP membership ID, drug, date of prescription/refill, number of days supplied, pharmacy and prescriber.

4. Manages and collects manufacturers' rebates on prescription drugs as allowed by the 340B Drug Pricing Program.

    a. Invoices manufacturers for rebates and maintains rebates minus an administrative fee in an account for ADAP. ADAP is not responsible for repaying any rebates billed in error.

5. Provides timely and successful troubleshooting and resolution of billing issues at the pharmacy level.

    a. Provides capable technical Help Desk staff to address eligibility and pharmacy issues related to claims processing and billing. Staff must be available by phone and email at least during weekday business hours of 8:00 a.m. to 5:00 p.m. ET. Typical support functions will include receiving member eligibility instructions from ADAP concerning new and continuing members, assisting with coordination of benefits questions from ADAP and from pharmacies and troubleshooting for members having problems obtaining their drugs at the pharmacy.

6. Holds data strictly confidential.

    a. Provides ADAP with a copy of its confidentiality policy to demonstrate high standards of data security and confidentiality. All staff with access to ADAP data will be required to sign the Department's confidentiality agreement on an annual basis. ADAP member information may not be used for commercial purposes.

7. Works closely with ADAP staff to ensure successful implementation of the program.

    a. Provides a written estimate of cost for any electronic systems upgrades prior to initiating such upgrades, and informs ADAP when the successful Bidder has reached 75% of the cost estimate in the event that the successful Bidder anticipates a greater cost.
    b. Manages the Formulary as defined by ADAP. The formulary includes individual drugs and whole classes of drugs. ADAP will occasionally request addition of specific drugs to the formulary. The successful Bidder will automatically add drugs to the formulary when the Food & Drug Administration (FDA) adds new drugs to approved classes. ADAP may choose not to add individual drugs to the formulary or to require prior authorization for various reasons. The successful Bidder will be responsible for costs incurred for any drugs the successful Bidder adds to the formulary in error. The successful Bidder will send an electronic copy of the formulary to ADAP every quarter along with a summary of changes from the previous quarter.
    c. Meets with ADAP staff to resolve technical or contractual problems that may occur during the term of the resulting contract or to discuss the progress made in the performance of obligations, at no additional cost to ADAP. Meetings will occur as problems arise and will be coordinated by ADAP. The successful Bidder will be given a minimum of three working days' notice of meeting date, time, and location. Face-to-face meetings are desired. However, at the successful Bidder's option and expense, a conference call meeting may be substituted. Consistent failure to participate in problem resolution meetings, failure to make a good faith effort to resolve problems or two consecutive missed or rescheduled meetings may result in termination of the contract.

B. Reporting - Reports and Data Required for ADAP:

1. Monthly Usage – line-listed claims data (including reversals) formatted for import into the ADAP's data system for annual federal reporting and transmitted via secure web-based data transfer.

    a. Due the 15th of the following month.
    b. See Appendix H ("ADAP Claims Data Import Specifications") for details about the information to be transmitted and how it must be formatted.

2. Monthly Prior Authorizations and Overrides – identification of the date, the drug, the amount paid, the prior authorization number, and the member's ADAP coverage group and membership ID.

    a. Due the 15th of the following month.
    b. The Department has no specific preference for format as long as all required data elements are included.

3. Monthly ADAP Adherence Report – identification of members who have picked up drugs early, late or who did not show up to get their drugs and which includes ADAP membership ID, drug, date of prescription/refill, number of days supplied, pharmacy and prescriber.

    a. Due the 15th of the following month.
    b. Must be delivered in an editable format (preferably Microsoft Excel).

4. Quarterly ADAP Formulary Report – identification of all drugs currently covered by ADAP by drug class and drug name; a product description, including whether the drug is a brand or generic, effective date the drug was added to the Formulary, date drug was removed from the Formulary (if applicable; and indicating if a Prior Authorization is required.

    a. Due 15 days after the close of each quarter.
    b. The Department has no specific preference for format as long as all required data elements are included.

5. Quarterly Drug Rebate Report – identification of rebates invoiced and funds received during quarter.

    a. Due 15 days after the close of each quarter.
    b. The Department has no specific preference for format as long as all required data elements are included.

6. Invoices – Invoices for all ADAP claims, reports and administrative fees shall be submitted to the ADAP for payment twice per month. Invoices include summary data that reconcile totals from claims data with any adjustments.

7. Additional periodic reports as requested by ADAP for an additional fee. The fee shall be negotiated at the time of the request for the additional report based upon the estimate of time to create, test, and produce the report.

PART III KEY RFP EVENTS

A. Timeline of Key RFP Events

Event Name	Event Date and Time
Due Date for Receipt of Written Questions	10/23/2015 at 5:00 p.m., local time
Due Date for Receipt of Proposals	12/15/2015 at 2:00 p.m., local time
Estimated Contract Start Date (subject to change)	January 1, 2017

B. Questions

1. **General Instructions**
   a. It is the responsibility of each Bidder to examine the entire RFP and to seek clarification in writing if the Bidder does not understand any information or instructions.
   b. Questions regarding the RFP must be submitted in writing and received by the RFP Coordinator listed on the cover page of this RFP document as soon as possible but no later than the date and time specified in the timeline above.
   c. Questions may be submitted by e-mail, and include the RFP Number and Title in the subject line. The Department assumes no liability for assuring accurate/complete/on time e-mail transmission and receipt.
   d. Include a heading with the RFP Number and Title. Be sure to refer to the page number and paragraph within this RFP relevant to the question presented for clarification, if applicable.

2. **Summary of Questions and Answers:** Responses to all substantive and relevant questions will be compiled in writing and distributed to all registered, interested persons by e-mail no later than seven (7) calendar days prior to the proposal due date. Only those answers issued in writing by the RFP Coordinator will be considered binding. The Department reserves the right to answer or not answer any question received.

C. Submitting the Proposal

1. **Proposals due:** Proposals must be received no later than **2:00 p.m. local time**, on the date listed in the timeline above, at which point they will be opened. Proposals received after the 2:00 p.m. deadline will be rejected without exception.

2. **Mailing/Delivery Instructions:** PLEASE NOTE: The proposals are not to be submitted to the RFP Coordinator at the requesting Department. The official delivery site is the State of Maine Division of Purchases (address shown below).
   a. Only proposals received at the official delivery site prior to the stated deadline will be considered. Bidders submitting proposals are responsible for allowing adequate time for delivery. Proposals received after the 2:00 p.m. deadline will be rejected without exception. Postmarks do not count and fax or electronic mail transmissions of proposals are not permitted unless expressly stated in this RFP. Any method of hardcopy delivery is acceptable, such as US Mail, in-person delivery by Bidder, or use of private courier services.
   b. The Bidder must send its proposal in a sealed package including **one (1) original and six (6) copies** of the complete proposal. Please clearly label the original. One electronic copy of the proposal must also be provided on CD or flash drive with the complete narrative and attachments in MS Word format. Any attachments that cannot be submitted in MS Word format may be submitted as Adobe (.pdf) files.
   c. Address each package as follows (and be sure to include the Bidder's full business name and address as well as the RFP number and title):

Bidder Name/Return Address

Division of Purchases
Burton M. Cross Building, 4th Floor
111 Sewall Street
9 State House Station
Augusta ME 04333-0009

Re: RFP # 201509159

PART IV PROPOSAL SUBMISSION REQUIREMENTS

This section contains instructions for Bidders to use in preparing their proposals. The Bidder's proposal must follow the outline used below, including the numbering and section and sub-section headings as they appear here. Failure to use the outline specified in this section or to respond to all questions and instructions throughout this document may result in the proposal being disqualified as non-responsive or receiving a reduced score. The Department and its evaluation team for this RFP have sole discretion to determine whether a variance from the RFP specifications should result in either disqualification or reduction in scoring of a proposal. Rephrasing of the content provided in this RFP will, at best, be considered minimally responsive. The Department seeks detailed yet succinct responses that demonstrate the Bidder's experience and ability to perform the requirements specified throughout this document.

A. Proposal Format

1. For clarity, the proposal should be typed or printed. Proposals should be single-spaced with 1" margins on white 8 ½" x 11" paper using a font no smaller than 12 point Times New Roman or similar.
2. All pages should be numbered consecutively beginning with number 1 on the first page of the narrative (this does not include the cover page or table of contents pages) through to the end, including all forms and attachments. For clarity, the Bidder's name should appear on every page, including Attachments. Each Attachment must reference the section or subsection number to which it corresponds.
3. Bidders are asked to be brief and to respond to each question and instruction listed in the "Proposal Submission Requirements" section of this RFP. Number each response in the proposal to correspond to the relevant question or instruction of the RFP. The proposal should be limited to a maximum total of 200 pages. Pages provided beyond the aforementioned maximum amount will not be considered during evaluation.
4. The following proposal elements, if applicable/requested, will not be counted as part of the maximum total number of pages allowed for the proposal: proposal cover page, table of contents, financial forms, any required attachments, appendices, or forms provided by the Department in the RFP, organizational charts, job descriptions, or staff résumés.
5. The Bidder may not provide additional attachments beyond those specified in the RFP for the purpose of extending the response. Any material exceeding the proposal limit will not be considered in rating the proposals and will not be returned. Bidders shall not include brochures or other promotional material with their proposals. Additional materials will not be considered part of the proposal and will not be evaluated.
6. Include any forms provided in the application package or reproduce those forms as closely as possible. All information should be presented in the same order and format as described in the RFP.
7. It is the responsibility of the Bidder to provide all information requested in the RFP package at the time of submission. Failure to provide information requested in this RFP may, at the discretion of the Department's evaluation review team, result in a lower rating for the incomplete sections and may result in the proposal being disqualified for consideration.
8. Bidders shall complete and submit the proposal cover page provided in Appendix A of this RFP and provide it with the Bidder's proposal. The cover page must be the first page of the proposal package. It is important that the cover page show the specific information requested, including Bidder address(es) and other details listed. The proposal cover page shall be dated and signed by a person authorized to enter into contracts on behalf of the Bidder.

B. Appeal Deposit

Each Bidder of this RFP must provide a deposit in the amount of $5,000.00 to offset expenses incurred by the State of Maine during the award process. This deposit must be payable to the "Treasurer of the State of Maine" in the form of a certified, cashier's or teller's check.

In the event the award process for this RFP involves a hearing of appeal, expenses will be assessed if the appeal request is found to be without merit, or the hearing of appeal results in a validation of the Department's award. Otherwise, deposits are refundable to all Bidders.

Bidders are to complete Appendix E and submit that form with the appeal deposit check in a sealed envelope clearly marked "Appeal Deposit" with their proposal.

For the purposes of this Section, failure of the State of Maine to award a contract as a result of this RFP does not constitute grounds for assessing expenses.

Proposals received that do not include an Appeal Deposit will be rejected without exception and ineligible for award consideration.

C. Proposal Contents

Section I Organization Qualifications and Experience

1. Overview of the Organization

Present a brief statement of qualifications and short summary of relevant experience. If subcontractors are to be used state the total percentage of work to be subcontracted and identify each subcontractor by name, address, phone number, contact person, and a brief description of the subcontractors' organizational capacity and qualifications.

Bidders shall:

a. State the organization's full company and corporate name and give the address of the organization's headquarters office.
b. Specify how the entity is organized (proprietorship, partnership, corporation).
c. Specify the state in which the Bidder is incorporated or otherwise organized to do business.
d. Provide the Federal Employer Identification Number (FEIN).
e. Attach a copy of the face page of the Bidders general liability, professional liability and any other relevant liability insurance policies that might be associated with this contract (Attachment 6).
f. Specify name and address of subcontractor and percentage of work to be performed by subcontractor(s), if any.
g. Confidentiality and data security policy. The policy should describe how confidential information is stored, who has access to it and methods of protecting confidentiality.

2. Organizational Experience

Briefly describe the history of the Bidder's organization, especially regarding skills pertinent to the specific work required by the RFP and any special or unique characteristics of the organization which would make it especially qualified to perform the required work activities. Include similar information for any subcontractors.

In addition, Bidder shall provide the following:

a. Three (3) current business references with contact information that can provide information on the vendor's experience and competence to perform projects similar to the MaineCare PBM project. These must be attached in Attachment 5.

    1. Provide one reference from a bank or creditor (this is in addition to the three references required above) that Bidder is in good standing (attached as Attachment 5).
    2. Provide information to demonstrate Bidder's financial capacity to include

a. Bank statement on amount of available line of credit (attach as Attachment 6)
b. A letter from a surety or bonding company demonstrating Bidder's ability to obtain a Performance Bond (attach as Attachment 6). A Performance Bond in the amount of 10% of the annual contract amount shall be required and must be submitted to the Department within 10 calendar days of execution of the contract. This bond shall be used in the event the Bidder becomes unable to properly, promptly and effectively perform the contract, of it the contract is terminated by default of bankruptcy.
c. Bidders shall attach a copy of the most current Dunn and Bradstreet Comprehensive Insight Plus Report on their corporate entity and copies of Bidder's audited financial statements for the three most recent years (attach as Attachment 7). If a Bidder is either substantially or wholly owned by another corporate entity, the Bidder must also include same for the parent organization and a statement that the parent will unconditionally guarantee performance by the Bidder in each and every term, covenant, and condition of such contract as may be executed by the parties. Any proposed subcontractor whose percentage of work to be performed (measured as percentage of total contract price) is 20 percent or more must submit this required information as well. Additional financial information may be requested during the evaluation process.

3. Description of Experience with Similar Projects

a. Project Staff Qualifications

The Bidder will submit resumes and contact information for 3 references for all key personnel and also provide a short narrative description of relevant experience. Resumes containing incorrect information or information which is no longer current will be deemed non-responsive.

The Project Manager and Implementation Manager will be required to work on-site with State staff during the **Analysis, configuration and deployment** phase.

b. Project Staffing Plan

The Bidder shall identify key personnel. At a minimum, OMS requires a Project Manager and Implementation Manager, and technical and clinical resources to meet the RFP requirements. Bidder should also include its process for conducting and documenting employee background checks.

The Bidder will identify roles and responsibilities of the Implementation Phase key personnel.

The Bidder's project team organization chart and descriptions of the functions to be performed by each position shall be included. The PBM will identify and describe roles and responsibilities of the project team.

The organization chart with descriptions of functions to be performed by each position and key resumes shall be attached as Attachment 1.

Also required is a staff loading chart keyed to all tasks identified in Schedule 2 that shows, by month, the position of key personnel assigned and how many person days each individual will work on the project during each project month. Non-key resources must be shown by labor category so that the staffing chart will show the total effort by key personnel and/or labor category by task and by month.

Bidder shall identify the fiscal controls and accounting practices that assure against fraud or abuse of funds, including how the Bidder ensures the final accountability of its sub-contractors. Include a description of how the Bidder would take corrective/disciplinary action upon detection of fraud or abuse and how it would notify the Department.

Section II Proposed Services

1. Services to be Provided

The requirements below relate directly to the solution and services that are being requested. In those subsections requiring the development of a plan, with the exception of item 14 below, the expectation is that the methodology for the development of the plan will be discussed in PBM proposal.

2. Response to Requirements

In the response to requirements, the PBM must explain how each task will be accomplished for Part II, Scope of Work. For those requirements that Bidder does not explain how the task will be accomplished, they will be considered unmet. The PBM's must confirm that all State and Federal requirements, including CMS certification requirements, will be met in their proposed solution.

Bidders should ensure that any additional requirements for the implementation and operation of the PBM beyond those stated by the RFP are included and considered.

3. Configuration Sessions

Describe the approach to configuration sessions. How are open issues and requested modifications identified and tracked? What is the approach to documenting and receiving OMS approval for the outcomes of the sessions?

The selected PBM will be required to begin configuration sessions with the State on a schedule approved by the OMS Project Manager, to determine and detail final requirements for this procurement. The configuration sessions for requirements definition must begin immediately upon contract execution. The configuration sessions for requirements definition must be included on the PBM's updated work plan which will be incorporated into the contract as a deliverable. The requirements definition must be completed within three months from the beginning configuration session.

4. Change Management

Please describe the approach to Change Management and how it will be communicated to OMS.

5. General/Detailed System Design

Describe the approach to the development of the General and Detailed System Design Documents. What do you, the PBM, expect to include in the design documents; e.g. screen mock-ups, report definitions, etc.?

6. Modification, Transfer of System

PBM must describe approach to installing, modifying, and configuring the PBM software to tailor it to MaineCare program requirements. Describe the change control process and the version control software that will be used to track the review, approval, and completion of required modifications. In addition, describe your approach to development, distribution, and training related to user manuals for both OMS staff and providers.

7. Security, Confidentiality, Auditing, and Disaster Recovery

As this system will be remotely hosted, describe the approach to security, confidentiality, and auditing. Include a description of data safeguards and physical security at development and local sites.

Provide assurances that the PBM design, development, and implementation are in accordance with State and Federal regulations and guidelines related to security, confidentiality, and auditing, in addition to HIPAA Business Associate Agreement (BAA) requirements governing the use of protected health information (PHI).

Describe system backup and recovery features to ensure that development and testing efforts can continue if automated system tools become unavailable and that the system can be reconstructed in the case of a disaster at the PBM's site.

The PBM must submit a Business Continuity and Disaster Recovery Plan to the Department for review and approval thirty (30) calendar days prior to start of operations. The PBM must incorporate modifications required by the Department within ten (10) calendar days of notification. In no case will the PBM be allowed to begin operations without an approved Business Continuity and Disaster Recovery Plan. The PBM shall update the plan on an annual basis and submit a complete revised plan within fifteen (15) business days following the end of the Contract year. In addition, the PBM must complete interim updates within ten (10) business days of change in procedures.

The PBM must develop and maintain a Business and Continuity and Disaster Recovery Plan designed to minimize any disruption to pharmacy claims processing caused by a disaster at the PBM's central business office or other facilities. It is the sole responsibility of the PBM to maintain adequate backup to ensure minimal disruption of services.

At a minimum, the Business Continuity and Disaster Recovery Plan must include the following components:

- Measures taken to minimize the threat of a disaster at the PBM's central Maine business office, including physical security and fire detection and prevention;
- Provision for accepting telephone calls from pharmacies and medical providers in the event of a disaster or the failure of PBM's telephone or computer system;
- Procedures utilized to minimize the loss of required records in the event of fire, flood, or other disaster; and
- Off-site storage.

8. Insurance Requirements

The Provider shall procure and maintain, for the duration of the Agreement, insurance against claims for injuries to persons, or damages to property, which may arise from, or in connection with, the fulfillment of this Agreement by the Provider, its agents, representatives, employees, or Subcontractors.

A. **<u>Minimum Coverage</u>**

i. Errors & Omissions / Professional Liability Insurance / or Insurance by any other name, in an amount of not less than $1,000,000 per occurrence, and as an annual aggregate, covering the following:

A) All acts, errors, omissions, negligence, infringement of intellectual property (except patent and trade secret);

B) Network security and privacy risks, including but not limited to unauthorized access, failure of security, breach of privacy, wrongful disclosure, collection, or other negligence in the handling of confidential information, related regulatory defense, and penalties;

C) Data breach expenses, in an amount not less than $*5,000,000*, and payable, whether incurred by the Department or the Provider; for and on behalf of the Department, including, but not limited to:

1) Consumer notification, whether or not required by law,
2) Forensic investigations,
3) Public relations and crisis management fees, and
4) Credit or identity monitoring, or similar remediation services.

The policy shall affirm coverage for contingent bodily injury and property damage emanating from failure of the Provider's technology services, or an error, or omission, in the content of, and information from, the Provider. If a sub-limit applies to any element of coverage, the certificate of insurance must specify the coverage section and the amount of the sub-limit. Insurance shall be secured by, and at the Provider's expense, and maintained in force, at all times during the term of this Agreement, and for a period of not less than two (2) years thereafter for services completed during the term of the Agreement.

NOTE: *Personally-Identifiable Information (PII) is information that can be used to identify a single person, such as name, social security number, date and place of birth, mother's maiden name, driver's license, biometrics, etc. Maine State law also has a more specific definition in 10 M.R.S. § 1347(6). The Data Breach component of the Insurance (per occurrence) is pegged to the number of PII records that are the subject of this Agreement.*

Number of PII Records	***Insurance per Occurrence***
Up to 3,000	*$400,000*
Up to 100,000	*$1,000,000*
Up to 1,000,000	*$5,000,000*
Greater than 1,000,000	*$10,000,000*

ii. Workers' Compensation and employer's liability: as required by law;

iii. Property (including contents coverage for all records maintained pursuant to this Agreement): $1,000,000 per occurrence.

iv. Automotive Liability of not less than $400,000 per occurrence single limit if the Provider will use vehicles to fulfill the contract;

v. Crime, in an amount agreed upon by the Successful Bidder and the Department *(The total monetary amount potentially at risk due to this contract; or Cash Currency and Negotiable Securities actually entrusted to this Provider).*

vi. Business Interruption, in an amount that would allow the Provider to maintain operations in the event of a Property loss.

B. **Other Provisions**

i. Unless explicitly waived by the Department, the insurance policies shall contain, or be endorsed to contain, the following provisions:

A. The Provider's insurance coverage shall be the primary and noncontributory. Any insurance or self-insurance maintained by the Department for its officers, agents, and employees shall be in excess of the Provider's insurance and shall not contribute to it.

B. The Provider's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the insurer's liability.

C. The Provider shall furnish the Department with certificates of insurance and with those endorsements, if any, effecting coverage required by these Insurance Requirements. The certificates and endorsements for each insurance policy are to be signed by a person authorized by the insurer to bind coverage on its behalf. All certificates and endorsements are to be received and approved by the Department before this Agreement commences. The Department reserves the right to require complete, certified copies of all required insurance policies at any time.

D. All policies should contain a revised cancellation clause allowing thirty (30) days' notice to the Department in the event of cancellation for any reason including nonpayment.

E. The Department will not grant the Provider or any sub-contractor of the Provider "Additional Insured" status and the Department will not grant any Provider a "Waiver of Subrogation".

9. Conversion

Describe the approach to the conversion of data necessary to operate the new PBM. What will be included in the conversion plan? Describe the approach to testing conversion programs, providing results to OMS for review and approval, and conducting the preliminary file conversions. Include proposed descriptions of OMS review process, including walkthroughs of the converted files.

10. System Test

Describe the approach to system testing. Including a discussion of the test plan, how test results will be communicated to OMS, and the use of any automated testing tools. Also include a discussion of the use of an integrated test facility.

11. User Acceptance Test

Describe the approach to User Acceptance Testing (UAT) including Pilot and Parallel Testing. Include a discussion of test environments, tracking tools, and issue tracking. A description of disaster recovery testing and contingency planning should be included in the acceptance test activity.

12. Implementation Plan

Describe the approach to implementing the new PBM. Include an approach to communications

that details how OMS providers will be notified of new procedures; how the transition from the current system will be accomplished; the approach to final file conversion; how risks will be identified, tracked and resolved; and the approach to training OMS and provider staff.

13. Certification Task

Bidders must discuss their approach to supporting OMS during system certification processes. PBMs must provide a certification plan for how the PBM will support OMS during the CMS Certification process.

14. Training Plan

Bidders must provide a high level training plan that addresses OMS' training needs under this RFP. Also discuss the development of user manuals and provider handbooks. Web based training materials and on-line tutorials are preferred.

15. Work Plan

Bidders must provide a high-level Work Plan that addresses task 2 – 16 in this section. (Attach as Attachment 2). Describe the approach to managing the implementation of the new PBM and the reporting on the progress to the Department. The PBM is expected to keep the Work Plan updated regularly. During project start up, the Department will discuss with the PBM the frequency of updates to the Work Plan to be provided to the Department. At a minimum, the Department requires the PBM to report weekly late and behind tasks as well as the reason for these tasks being late or behind. For late tasks, the Department requires a correction action to be documented.

16. Performance Testing

Bidders should provide a high level plan to address how they will ensure the proposed solution meets the performance expectations.

17. Technical Architectural Design

Bidders will submit a narrative and pictorial description of the proposed technical solution based upon the technical requirements as specified in this RFP in the environment information provided within Appendix F. Vendor information to be provided will include but not be limited to the following:

a. Description of Architectural Design
b. Introduction (System Design)
c. Assumptions (e.g. Out of Scope, In Scope)
d. Framework/Architecture (Physical, Application) including architectural diagram
e. Structural Design (Database, Application Code, Business Logic, Programs)
f. Security (Authentication, Authorization, Data Protection, Auditing, Physical and Network)

Section III Cost Proposal

1. Total Cost Summary – Appendix B, Schedule 1

This form must be used to provide the total fixed cost for the analysis, configuration, and deployment for the solution, which will be evaluated and scored as part of this procurement. Please note that these forms cannot be modified in any way.

Schedules 2 through 5 must be completed and totals carried to Schedule 1 to propose a firm fixed cost for the solution.

The cost proposal shall include the costs necessary for the PBM to fully comply with the contract terms and conditions and RFP requirements.

Failure to provide the requested information in the Schedules may result in the exclusion of the proposal from consideration, at the discretion of the Department.

No costs related to the preparation of the proposal for this RFP or to the negotiation of the contract with Department may be included in the proposal. Only costs to be incurred after the contract effective date that are specifically related to the implementation or operation of the contracted services may be included.

2. **Appendix B, Analysis, configuration and deployment – Schedule 2**
Bidders are required to identify the total fixed cost for the **Analysis, configuration and deployment** Activities. Identified tasks in Schedule 2 are not all inclusive to this project. PBMs must identify any and all costs necessary for the **Analysis, configuration and deployment** of this solution whether or not they fall into the categories listed in Schedule 2.

   Bidders must estimate breakout costs for individual tasks at this time. Bidders must explain the methodology for how they arrived at the total fixed cost for the analysis, configuration and deployment. The selected Bidder will be required to provide a detailed cost breakdown in a format provided by OMS during contract negotiations.

   The total cost is to be carried to Schedule 1.

3. **Appendix B, Operations – Schedule 3**
The Bidder must specify a firm fixed price to perform all PBM Operations services for the initial base contract year. Bidders should use claims volume data provided by OMS to compute the annual costs for the first year:

   a. SFY14 All Claims: 4,768,921 (includes Medicaid, Maine Rx, Drugs for the Elderly and Medicare Part D).
   b. SFY14 PAs: 122,774 (Averaging 30,694 per quarter)
   c. CY14 ADAP Claims: 13,488 total with an average of 28 PAs per month
   d. SFY14 PTM NRT Claims: 9,465 vouchers
   e. SFY14 TB Claims: 1,929

   Then the Bidder must use that base year cost to calculate the total operations costs for an eight (8) year period.

   All costs (computer time, personnel, facilities, equipment, supplies, and documentation support) for system maintenance and modification, and other support staff needed to address stated business needs, are to be included in this fixed price bid for each year. Bidders must not include costs for postage in the Operations Costs since these are reimbursement (pass through) costs as defined in the RFP.

   The Fixed price bid for operations years will not be adjusted based on changes in recipient caseload, certified providers, claims volume, or volumes of other transactions or items processed by the PBM.

   The total cost is to be carried to Schedule 1.

4. **Appendix B, License – Schedule 4**
The Bidder must identify and describe any proprietary licenses to allow use and access to the proposed

system.

5. **Appendix B, Modifications – Schedule 5**
   This form will provide the hourly billing rates that will be in effect through the full term of the contract for the various staff performing work for the project. The rates that are provided within the cost form will be utilized to calculate charges for any work that is performed by the successful PBM above and beyond the scope of work (e.g. Change Order, Consulting Services) as it is defined within this RFP.

6. **Payment Schedule**
   The Bidder will submit a proposed payment schedule that is based upon milestones that relate to the official approval of one or more deliverables. The payment schedule must clearly indicate the deliverable(s) associated with each milestone. The Bidder will include proposed payment schedule in **Appendix B.**

7. **Budget Narrative**
   Bidders are to include a brief budget narrative to explain the basis for determining the expenses submitted on the budget forms. (Please note: The budget narrative will not count against the narrative page limited stated in PART IV, Section A., subsection 3.)

Section IV Economic Impact within the State of Maine

Using the form in Appendix C, the Bidder is required to describe the Bidder's recent and anticipated economic impact upon and within the State of Maine. The use of economic impact in making contract award decisions is required in accordance with Executive Order 2012-004, which states that certain service contracts "…advertised for competitive bid shall include scoring criteria evaluating the responding Bidder's economic impact on the Maine economy and State revenues."

Section V Required Proposal Attachments

The following attachments are required to be submitted with the proposal.

Attachment 1 – Organization Chart and Resumes of Key Staff
Attachment 2 – High Level Work Plan
Attachment 3 – Letters of Reference (3 business & 1 bank/creditor)
Attachment 4 - Letter from surety or Bond Company, bank statement on available line of credit, and Insurance Certificates
Attachment 5 – Dunn and Bradstreet Comprehensive Insight Plus Report and Audited Financial Statements 3 Most Recent Years
Attachment 6 – Confidentiality and data security policy.

PART V PROPOSAL EVALUATION AND SELECTION

Evaluation of the submitted proposals shall be accomplished as follows:

A. Evaluation Process - General Information

1. An evaluation team, comprised of qualified reviewers, will judge the merits of the proposals received in accordance with the criteria defined in the RFP, and in accordance with the most advantageous cost and economic impact considerations (where applicable) for the Department.
2. Officials responsible for making decisions on the selection of a contractor shall ensure that the selection process accords equal opportunity and appropriate consideration to all who are capable of meeting the specifications. The goals of the evaluation process are to ensure fairness and objectivity in review of the proposals and to ensure that the contract is awarded to the Bidder whose proposal best satisfies the criteria of the RFP at a reasonable/competitive cost.
3. The Department reserves the right to communicate and/or schedule interviews/presentations with Bidders if needed to obtain clarification of information contained in the proposals received, and the Department may revise the scores assigned in the initial evaluation to reflect those communications and/or interviews/presentations. Interviews/presentations are not required, and changes to proposals will not be permitted during any interview/presentation process. Therefore, Bidders should submit proposals that present their costs and other requested information as clearly and completely as possible.

B. Scoring Weights and Process

1. **Scoring Weights:** The score will be based on a 100 point scale and will measure the degree to which each proposal meets the following criteria.

   Section I. Organization Qualifications and Experience (25 points)
   Includes all elements addressed above in Part IV, Section I.

   Section II. Specifications of Work to be Performed (35 points)
   Includes all elements addressed above in Part IV, Section II.

   Section III. Cost Proposal (30 points)
   Includes all elements addressed above in Part IV, Section III.
   - **a.** Cost Proposal (25 points)
   - **b.** Cost/Budget Narrative (5 Points)

   Section IV. Economic Impact within the State of Maine (10 points)
   Includes all elements addressed above in Part IV, Section IV.
   - **a.** Recent Economic Impact (5 points)
   - **b.** Projected Economic Impact (5 Points)

2. **Scoring Process:** The review team will use a consensus approach to evaluate the bids. Members of the review team will not score the proposals individually but instead will arrive at a consensus as to assignment of points on each category of each proposal. The contract award(s) will be made to the Bidder(s) receiving the highest number of evaluation points, based upon the proposals' satisfaction of the criteria established in the RFP. The Cost and Economic Impact sections will be scored according to a mathematical formulas described below.

3. **Scoring the Cost Proposal:** The total cost proposed for conducting all the functions specified in this RFP will be assigned a score according to a mathematical formula. The lowest bid will be awarded **25**

points. Proposals with higher bids values will be awarded proportionately fewer points calculated in comparison with the lowest bid.

The scoring formula is:

(Lowest submitted cost proposal / Cost of proposal being scored) x **25** = pro-rated score

No Best and Final Offers: The State of Maine will not seek a best and final offer (BAFO) from any Bidder in this procurement process. All Bidders are expected to provide their best value pricing with the submission of their proposal.

The remaining **five (5)** points allocated to the Cost Proposal will be used to evaluate the responsiveness of the Budget Narrative material and supporting documentation contained with this section including: accuracy and reasonableness (assumptions used in calculating the costs), budget and financial stability.

4. **Scoring the Economic Impact:** The Economic Impact for this RFP will be assigned a score according to a mathematical formula.

   Recent Economic Impact: The highest recent economic impact will be awarded **5** points. Proposals with lower recent economic impact will be awarded proportionately fewer points calculated in comparison with the highest impact.

   The Recent Economic Impact scoring formula is:

   (Recent Economic Impact proposal being scored / Highest submitted recent Economic Impact proposal) x 5 = pro-rated score

   Projected Economic Impact*: The highest projected economic impact will be awarded 5 points. Proposals with lower projected economic impact will be awarded proportionately fewer points calculated in comparison with the highest projected economic impact.

   The Projected Economic Impact scoring formula is:

   (Projected Economic Impact proposal being scored / Highest submitted projected Economic Impact proposal) x 5 = pro-rated score

   Projected Economic Impact is to be based **solely on the resulting contract should the Bidder be awarded the contract for these services.*

   Please note: If the State determines that the Bidder's recent and/or projected economic impact information is deemed to be substantially inaccurate, then the State may not award

5. **Negotiations:** The Department reserves the right to negotiate with the successful Bidder to finalize a contract at the same rate or cost of service as presented in the selected proposal. Such negotiations may not significantly vary the content, nature or requirements of the proposal or the Department's Request for Proposals to an extent that may affect the price of goods or services requested. The Department reserves the right to terminate contract negotiations with a selected respondent who submits a proposed contract significantly different from the proposal it submitted in response to the advertised RFP. In the event that an acceptable contract cannot be negotiated with the highest ranked Bidder, the Department may withdraw its award and negotiate with the next-highest ranked Bidder, and so on, until an acceptable contract has been finalized. Alternatively, the Department may cancel the RFP, at its sole discretion.

C. Selection and Award

1. The final decision regarding the award of the contract will be made by representatives of the Department subject to approval by the State Purchases Review Committee.
2. Notification of contractor selection or non-selection will be made in writing by the Department.
3. Issuance of this RFP in no way constitutes a commitment by the State of Maine to award a contract, to pay costs incurred in the preparation of a response to this request, or to pay costs incurred in procuring or contracting for services, supplies, physical space, personnel or any other costs incurred by the Bidder.
4. The Department reserves the right to reject any and all proposals or to make multiple awards.

D. Appeal of Contract Awards

Any person aggrieved by the award decision that results from this RFP may appeal the decision to the Director of the Bureau of General Services in the manner prescribed in 5 MRSA § 1825-E and 18-554 Code of Maine Rules, Chapter 120 (found here: http://www.maine.gov/purchases/policies/120.shtml). The appeal must be in writing and filed with the Director of the Bureau of General Services, 9 State House Station, Augusta, Maine, 04333-0009 within 15 calendar days of receipt of notification of contract award.

PART VI CONTRACT ADMINISTRATION AND CONDITIONS

A. Contract Document

1. The successful Bidder will be required to execute a contract in the form of a State of Maine Agreement to Purchase Services (BP54). A list of applicable Riders is as follows:

Rider A: Specification of Work to be Performed
Rider B-IT: Method of Payment and Other Provisions
Rider C: Exceptions to Rider B
Rider D: Additional Requirements
Rider G: Identification of Country in Which Contracted Work Will Be Performed
Rider I: Maine State Department of Health and Human Services Insurance of Compliance
DHHS Business Associates Agreement

The complete set of standard BP54 contract documents may be found on the Division of Purchases website at the following link: http://www.maine.gov/dhhs/contracts/contract-2016/rider-b/Rider-B-IT.docx

Other forms and contract documents commonly used by the State can be found on the Division of Purchases website at the following link: http://www.maine.gov/purchases/info/forms.shtml

2. Allocation of funds is final upon successful negotiation and execution of the contract, subject to the review and approval of the State Purchases Review Committee. Contracts are not considered fully executed and valid until approved by the State Purchases Review Committee and funds are encumbered. No contract will be approved based on an RFP which has an effective date less than fourteen (14) calendar days after award notification to Bidders. (Referenced in the regulations of the Department of Administrative and Financial Services, Chapter 110, § 3(B)(i): http://www.maine.gov/purchases/policies/110.shtml

This provision means that a contract cannot be effective until at least 14 days after award notification.

3. The Department estimates having a contract in place by January 1, 2017. The State recognizes, however, that the actual contract effective date depends upon completion of the RFP process, date of formal award notification, length of contract negotiation, and preparation and approval by the State Purchases Review Committee. Any appeals to the Department's award decision(s) may further postpone the actual contract effective date, depending upon the outcome. The contract effective date may need to be adjusted to comply with mandated requirements.

4. In providing services and performing under the contract, the successful Bidder shall act independently and not as an agent of the State of Maine.

B. Standard State Agreement Provisions

1. Agreement Administration

a. Following the award, an Agreement Administrator from the Department will be appointed to assist with the development and administration of the contract and to act as administrator during the entire contract period. Department staff will be available after the award to consult with the successful Bidder in the finalization of the contract.

b. In the event that an acceptable contract cannot be negotiated with the highest ranked Bidder, the Department may withdraw its award and negotiate with the next-highest ranked Bidder, and so on,

until an acceptable contract has been finalized. Alternatively, the Department may cancel the RFP, at its sole discretion.

2. Payments and Other Provisions

The Department anticipates paying the Contractor on the basis of net 30 payment terms, upon the receipt of an accurate and acceptable invoice. An invoice will be considered accurate and acceptable if it contains a reference to the State of Maine contract number, contains correct pricing information relative to the contract, and provides any required supporting documents, as applicable, and any other specific and agreed-upon requirements listed within the contract that results from this RFP.

PART VII LIST OF RFP APPENDICES AND RELATED DOCUMENTS

1. Appendix A – State of Maine Proposal Cover Page
2. Appendix B – Cost Forms – Schedule 1 – 5, PBM's Proposed Payment Schedule
3. Appendix C – Economic Impact Form
4. Appendix D - TB Data Import Specifications
5. Appendix E - Appeal Deposit Refund Form
6. Appendix F – Current Application Architecture
7. Appendix G – Web PA/Preferred Drug List Portal
8. Appendix H – ADAP Claims Data Import Specifications
9. http://www.maine.gov/dhhs/oms/
10. http://www.tobaccofreekids.org/facts_issues/toll_us/maine
11. http://hab.hrsa.gov/abouthab/legislation.html
12. http://www.hrsa.gov/opa/
13. http://www.maine.gov/sos/cec/rules/10/ch101.htm
14. www.maine.gov/oit/policies
15. http://www.maine.gov/oit/policies/Remote-Hosting-Policy.htm
16. http://www.maine.gov/oit/policies/index.shtml
17. http://maine.gov/oit/policies/Application-Deployment-Certification.htm
18. http://maine.gov/oit/policies/Infrastructure-Deployment-Certification.htm
19. http://maine.gov/oit/policies/WebAccessibilityUsabilityPolicy.htm
20. http://hab.hrsa.gov/manageyourgrant/pinspals/adaptroopltr1011.pdf
21. http://www.maine.gov/dhhs/contracts/contract-2015/documents/Signature-BP54-IT.doc
22. http://www.maine.gov/purchases/info/forms.shtml
23. http://www.maine.gov/purchases/policies/110.shtml

PART VIII APPENDICES
Appendix A

State of Maine
Department of Health and Human Services
PROPOSAL COVER PAGE
RFP# 201509159
Pharmacy Benefit Manager and Point of Purchase System

Bidder's Organization Name:		
Chief Executive - Name/Title:		
Tel:	Fax:	E-mail:
Headquarters Street Address:		
Headquarters City/State/Zip:		
(provide information requested below if different from above)		
Lead Point of Contact for Proposal - Name/Title:		
Tel:	Fax:	E-mail:
Street Address:		
City/State/Zip:		

Proposed Cost from Schedule 1:	
The proposed cost listed above is for reference purposes only, not evaluation purposes. In the event that the cost noted above does not match the Bidder's detailed cost proposal documents, then the information on the cost proposal documents will take precedence.	

- This proposal and the pricing structure contained herein will remain firm for a period of 180 days from the date and time of the bid opening.
- No personnel currently employed by the Department or any other State agency participated, either directly or indirectly, in any activities relating to the preparation of the Bidder's proposal.
- No attempt has been made or will be made by the Bidder to induce any other person or firm to submit or not to submit a proposal.
- The undersigned is authorized to enter into contractual obligations on behalf of the above-named organization.

Debarment, Performance, and Non-Collusion Certification

By signing this document I certify to the best of my knowledge and belief that the aforementioned organization, its principals, and any subcontractors named in this proposal:

a. *Are not presently debarred, suspended, proposed for debarment, and declared ineligible or voluntarily excluded from bidding or working on contracts issued by any governmental agency.*
b. *Have not within three years of submitting the proposal for this contract been convicted of or had a civil judgment rendered against them for:*
    i. *fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a federal, state or local government transaction or contract.*
    ii. *violating Federal or State antitrust statutes or committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;*
    iii. *are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or Local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and*
    iv. *have not within a three (3) year period preceding this proposal had one or more federal, state or local government transactions terminated for cause or default.*
c. *Have not entered into a prior understanding, agreement, or connection with any corporation, firm, or person submitting a response for the same materials, supplies, equipment, or services and this proposal is in all respects fair and without collusion or fraud. The above mentioned entities understand and agree that collusive bidding is a violation of state and federal law and can result in fines, prison sentences, and civil damage awards.*

- **Failure to provide this certification may result in the disqualification of the Bidder's proposal, at the discretion of the Department.**

To the best of my knowledge all information provided in the enclosed proposal, both programmatic and financial, is complete and accurate at the time of submission.

Name:		Title:
Authorized Signature:		Date:

Appendix B

State of Maine
Department of Health and Human Services
COST PROPOSAL FORM
RFP# 201509159
Pharmacy Benefit Manager and Point of Purchase System

Bidder's Organization Name: _____

Total Costs Summary – Schedule 1

Analysis, configuration and deployment Phase (Total from Pricing Schedule 2)	$
Operations Phase (Total from Pricing Schedule 3)	$
License Costs (Total from Pricing Schedule 4)	$
Total Costs	$

Appendix B

State of Maine
Department of Health and Human Services
COST PROPOSAL FORM
RFP# 201509159
Pharmacy Benefit Manager and Point of Purchase System

Bidder's Organization Name: _____

Analysis, configuration and deployment – Schedule 2

Bidders must estimate breakout costs for individual tasks at this time. Identified tasks below are not all inclusive to this project. Bidders must identify any and all costs necessary for the Analysis, configuration and deployment of this solution whether or not they fall into the categories listed below. Bidders must explain the methodology for how they arrived at the total fixed cost for the Analysis, configuration and deployment. The selected vendor will be required to provide a detailed cost breakdown in a format provided by the State during contract negotiations.

ANALYSIS, CONFIGURATION and DEPLOYMENT	OMS	TB	PTM	ADAP
1. Requirements Definition	$	$	$	$
2. Change Management / Business Re-engineering	$	$	$	$
3. Design Task	$	$	$	$
4. Configuration Task	$	$	$	$
5. Conversion Task	$	$	$	$
6. System Testing Task	$	$	$	$
7. User Acceptance Testing Task	$	$	$	$
8. Implementation Task	$	$	$	$
9. CMS Certification Task	$	$	$	$
10. Training	$	$	$	$
Total Price for each column	$	$	$	$
Total Firm Fixed Price Bid for Analysis, configuration and deployment [add Total price from each column] (Transfer this amount to Schedule 1)	$			

Appendix B

State of Maine
Department of Health and Human Services
COST PROPOSAL FORM
RFP# 201509159
Pharmacy Benefit Manager and Point of Purchase System

Bidder's Organization Name: _____

Operations– Schedule 3

Bidder must provide an annual Firm Fixed Price that includes all hosting and operations functions, services, maintenance, and staffing for system operations as defined in the RFP.

OPERATIONS	OMS	TB	PTM	ADAP
Base Annual Year Amount	$	$	$	$
Total Price over Eight Years (multiply base annual year amount by 8)	$	$	$	$
Total Cost for Operations (Eight Year price for all Services) (Transfer this amount to Schedule 1)	$			

Appendix B

State of Maine
Department of Health and Human Services
COST PROPOSAL FORM
RFP# 201509159
Pharmacy Benefit Manager and Point of Purchase System

Bidder's Organization Name: _____

License – Schedule 4

	Unit Purchase	Extended	Annual Maintenance/ Services Fees	Year 1 Price	Year 2 Price	Year 3 Price	Year 4 Price	Year 5 Price	Year 6 Price	Year 7 Price	Year 8 Price
OMS	License Description	License Term/Period	Quantity								
TB	License Description	License Term/Period	Quantity								
PTM	License Description	License Term/Period	Quantity								
ADAP	License Description	License Term/Period	Quantity								
	TOTAL LICENSE COST (Add total price for years 1-8) (TRANSFER THIS AMOUNT TO SCHEDULE 1)		**$_____**	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Year 6 Total	Year 7 Total	Year 8 Total
	The Bidder must identify and describe any proprietary license to allow use and access to use the proposed system.										

Appendix B

State of Maine
Department of Health and Human Services
COST PROPOSAL FORM
RFP# 201509159
Pharmacy Benefit Manager and Point of Purchase System

Bidder's Organization Name: _____

Modifications – Schedule 5

The Bidder must provide an hourly rate for each staff classification listed below and also identify other technical staff classifications and the hourly rates for each that may be necessary to meet the State's business needs for any work above and beyond the scope of this RFP. These hourly billing rates will be in effect through the full term of the contract.

Classification	Fully Loaded Hourly Rate
Application Software Team Lead	
Programmer	
System Analyst	
Data Base Administrator	
Web Developer	
Network Administrator	
Others: Please List Separately	

Appendix C

State of Maine
Department of Health and Human Services
ECONOMIC IMPACT FORM
RFP# 201509159
Pharmacy Benefit Manager and Point of Purchase System

Instructions

In addition to all other information requested within this RFP, each Bidder should complete the tables below to quantify the Bidder's economic impact upon and within the State of Maine. The use of economic impact in making contract award decisions is outlined in Executive Order 2012-004, which states that certain contracts "…advertised for competitive bid shall include scoring criteria evaluating the responding Bidder's economic impact on the Maine economy and State revenues."

For the purposes of this RFP, the term "economic impact" shall be defined as the "Economic Impact Factors" listed in the table below. To complete the "economic impact" section of the Bidder's response, the Bidder shall provide the information requested, describing the Bidder's recent economic impact with the State of Maine and, separately, the projected economic impact with the State of Maine that would **specifically result from the awarded contract only**, should the Bidder be selected.

Recent Economic Impact (past 12-month period)

Economic Impact Factors	Factors Expressed in Dollars
Salaries paid to Maine residents in past 12-month period	$
Payments made to Maine-based subcontractors in past 12-month period	$
Payments of State and local taxes in Maine within past 12-month period	$
Payments of State licensing fees in Maine within past 12-month period	$
Total Recent Economic Impact	**$**

Projected Economic Impact (future 12-month period following contract award)

Economic Impact Factors	Factors Expressed in Dollars
Salaries to be paid to Maine residents in future 12-month period	$
Payments to be made to Maine-based subcontractors in future 12-month period	$
Payments of State and local taxes in Maine to be made in future 12-month period	$
Payments of State licensing fees in Maine to be made in future 12-month period	$
Total Projected Economic Impact only from awarded contract, if selected	**$**

For the tables above, the following definitions are provided:

- "Maine resident": any person whose primary residence is located within the State of Maine.
- "Maine-based": any organization whose primary operations are located within the State of Maine.
- "Past 12-month period": the past 12-months, starting on the date that the RFP was publicly released.
- "Future 12-month period": a projection for the future 12-month period, starting upon the "Estimated Contract Start Date" (PART III, A. of RFP).

Certification Statement

To the best of my knowledge, all information provided in the State of Maine Economic Impact Form is complete and accurate at the time of submission and I confirm that I am authorized to make such a determination on behalf of my organization.

Name:		Title:
Authorized Signature:		Date:

Appendix D

Maine TB Data Import Specifications

The TB Program needs the following data fields in the file format XML transmitted through a secure data transfer. The TB Program may request additional fields or formats from the bidder based on program needs.

TB data tables

Field Name- Description	Data Type	Field Name
Name of Client- First	Text	TBD
Name of Client- Middle	Text	TBD
Name of Client- Last	Text	TBD
Membership ID	Number	TBD
Drug name	Text	TBD
Pick up date of drug	Date/Time	TBD
Drug quantity	Number	TBD

Appendix E

State of Maine
Department of Health and Human Services
APPEAL DEPOSIT REFUND FORM
RFP# 201509159
Pharmacy Benefit Manager and Point of Purchase System

Instructions

Each Bidder is to provide an address below they wish to have the appeal deposit refund sent to. If this address is the same as either address provided on the Proposal Cover Page (Appendix A), Bidders are still required to complete this form and include it, along with the appeal deposit check, in a sealed envelope with their proposal.

Bidder's Organization Name:		
Attention to:		
Mailing Address (Street or P.O. Box):		
City:	State:	Zip Code:

Appendix F

Current Application Architecture

Inbound Interfaces:

- MEPOP System Claims In
- MEPOP System Claims Rejected
- MEPOP System Drug Rebate
- MEPOP System Labeler

Outbound Interfaces:

- MEPOP System Claims Out
- MEPOP System History Only Adjustment
- MEPOP System Prior Authorization
- MEPOP System Member
- MEPOP System Provider
- MEPOP System Third Party Liability
- MEPOP System Drug Rebate II

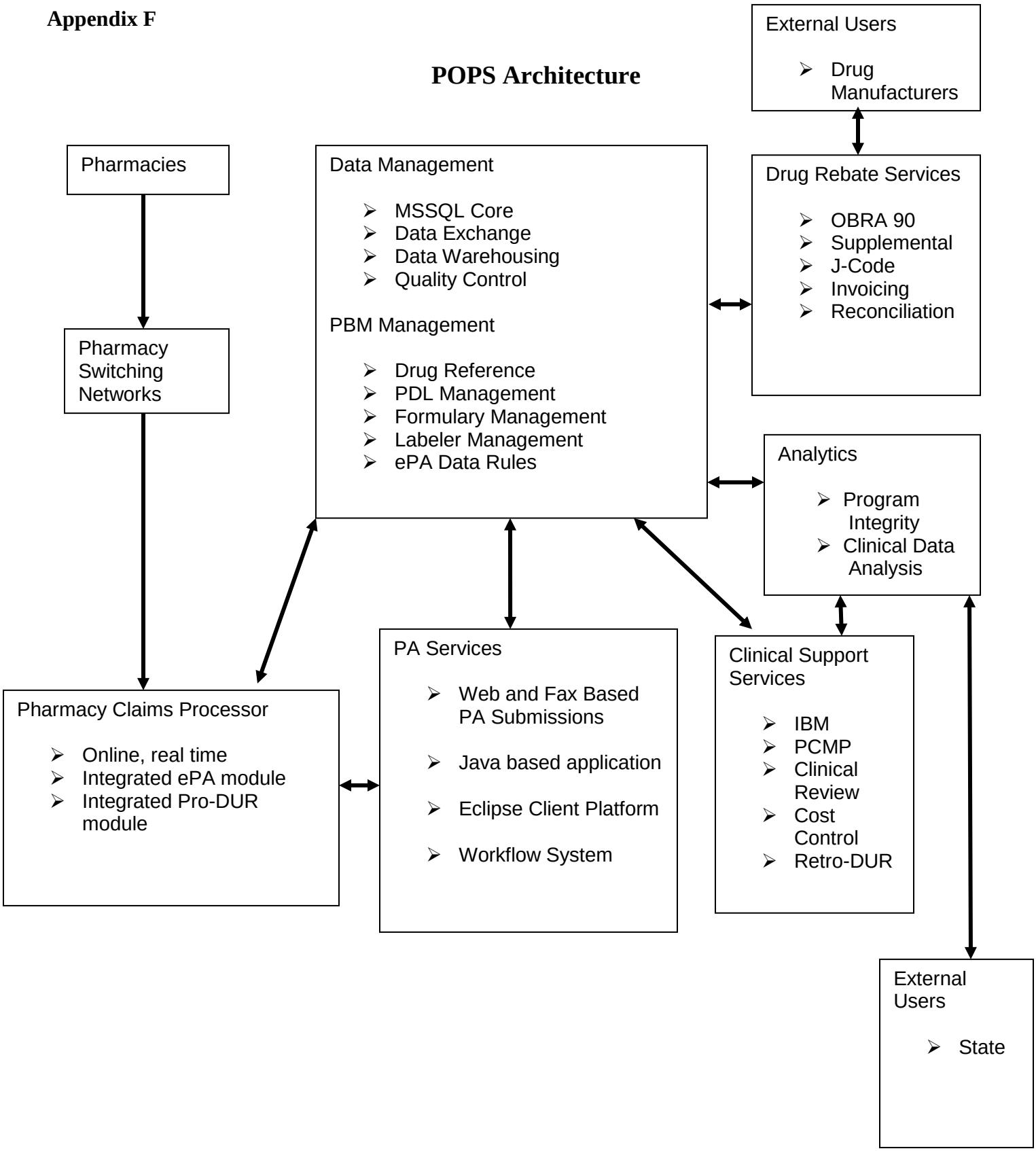
Other Interfaces:

- CMS
- MMIS/Fiscal Agent
- Eligibility
- Pharmacy
- Physician
- ePrescribing
- Drug File
- TPL
- RA’s
- Mailings
- Fax Blasts
- State

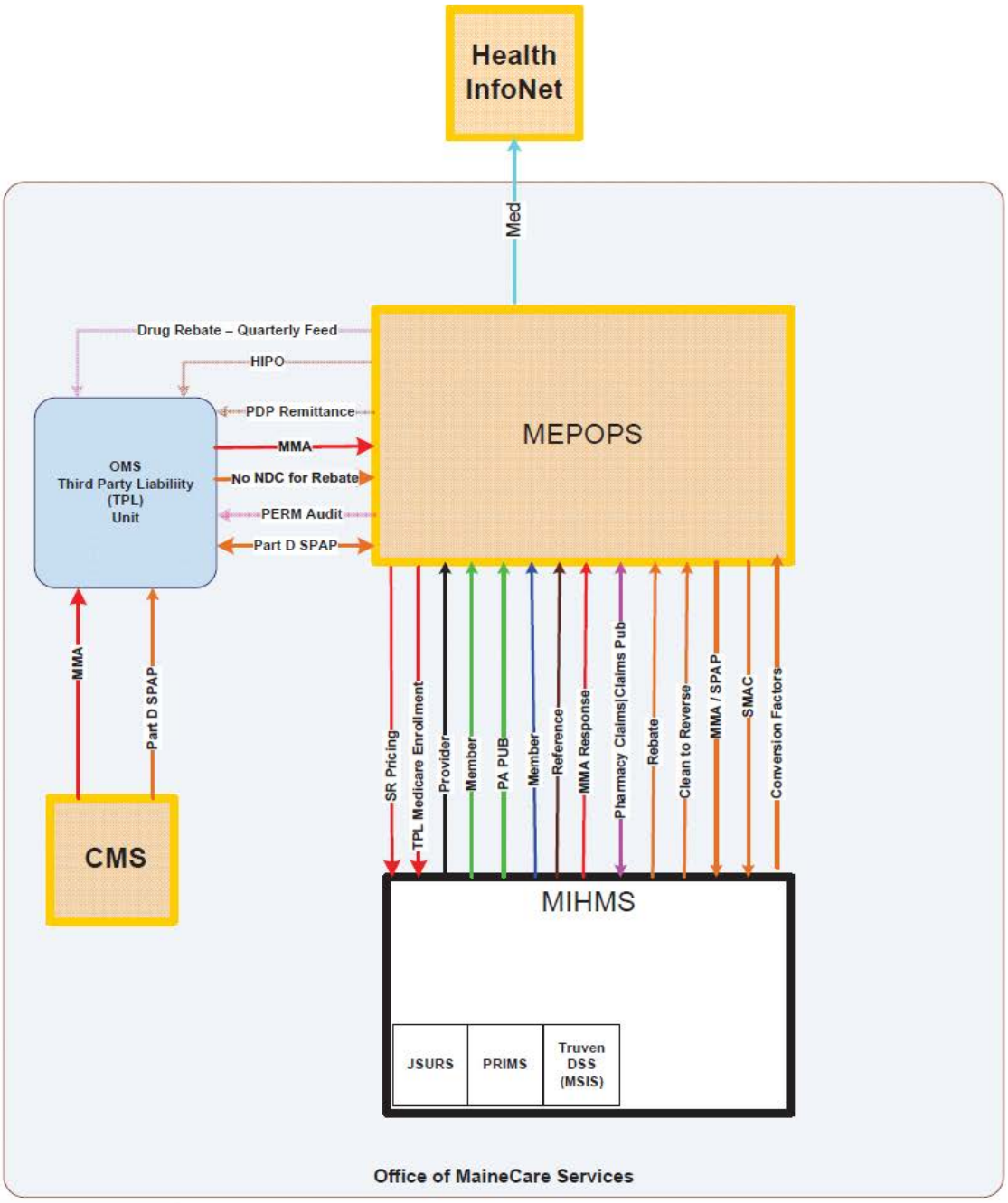
Two high level diagrams of system architecture are provided on the following pages.

Appendix F

POPS Architecture



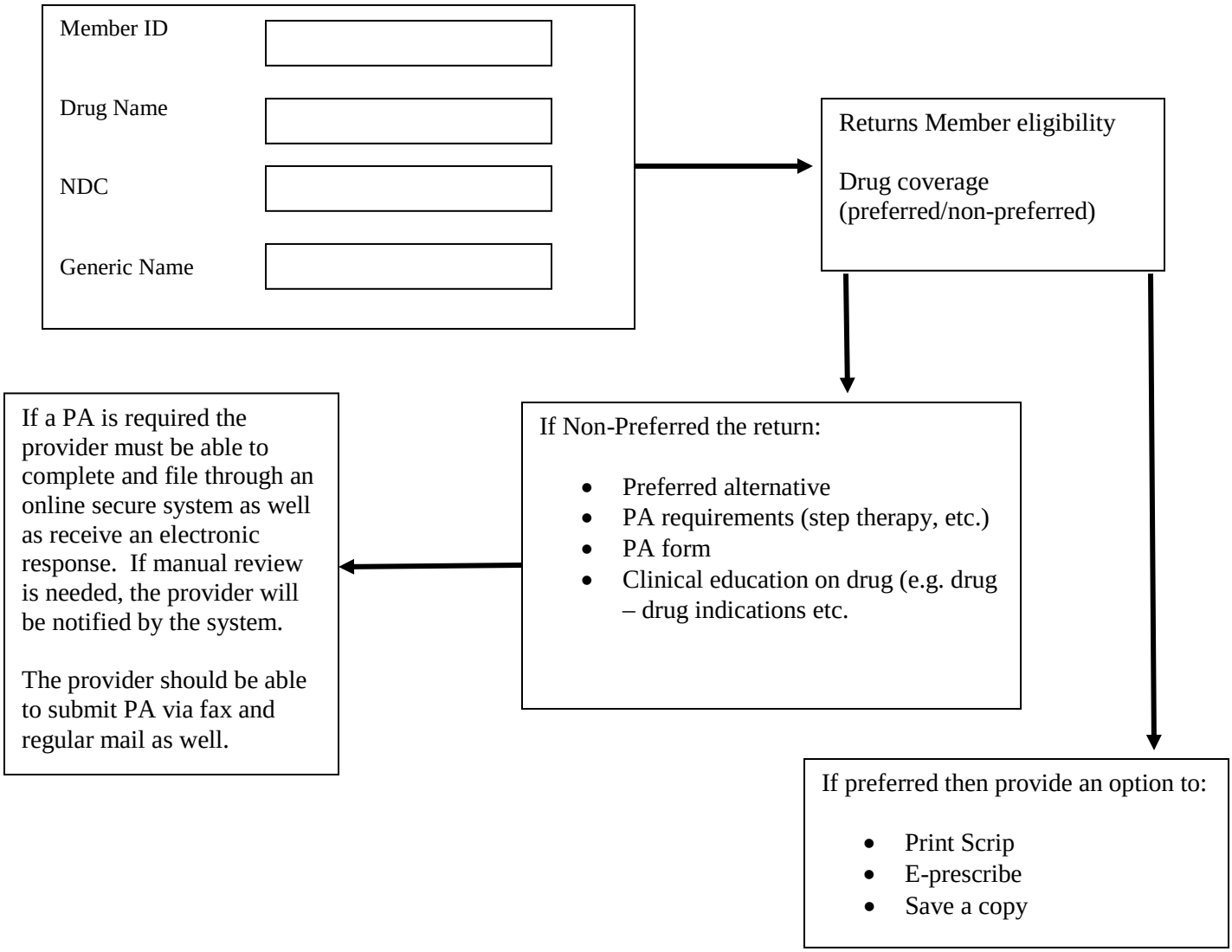
Appendix F
POPS & MIHMS
ARCHITECTURE



Appendix G

Web Prior Authorization (PA) / Preferred Drug List

The diagram below is an example of how the DHHS would like a PA/e-prescribing system to function. Please provide as much detail as possible when describing what your system can provide. Two items required are: 1) the provider must be able to log in to a secure web site and 2) provider must have access to real time information for eligibility and current PDL information.



Appendix H

Maine ADAP Claims Data Import Specifications

for CAREWare v 5.0 build 827

ADAP needs two Excel worksheets detailing claims data (including reversals). The first worksheet should be for all claims for which ADAP paid the full price of the medication as noted above. This worksheet should be labeled "exp_drug_payment" and should be formatted as specified below. The second worksheet should include all claims for which ADAP made a partial (wraparound) payment. It should be labeled "exp_service" and formatted as specified below. It is expected that these data will be produced and submitted to ADAP on a monthly basis for import into the CAREWare database.

exp_drug_payment

Field Name	Data Type	Length	Description/Comment
drg_py_pk	Text	38	Simple primary key for table
drg_py_delete	Yes/No	n/a	Default to False for all records
drg_py_cln_fk	Text	38	Assigned ADAP ID
drg_py_ndc	Text	11	Standardized NDC
drg_py_date	Date/Time	38	Date formatted as mm/dd/yyyy
drg_py_quantity	Single	n/a	Must be < or > 0 (a negative value is an adjustment)
drg_py_unit_price	Currency	n/a	Unit price. CAREWare multiplies this times quantity to calculate the total cost for the transaction.
drg_py_total	Currency	n/a	Include column but leave all values blank
drg_py_dispenser_code	Text	38	Unique code assigned to PBM for all records
drg_py_dispenser_label	Text	50	Label assigned to PBM for all records
drg_py_funding_code	Text	38	Should be "1" for all records
drg_py_insurance_code	Text	38	Should be "5" for all records
drg_py_funding_label	Text	50	Should be "ADAP" for all records
drg_py_insurance_label	Text	50	Should be "No Insurance" for all records
drg_py_comments	Text	255	Include column but leave all values blank
drg_py_dispense_fee	Currency	n/a	Dispensing fee for this disbursement
drg_py_duration	Single	n/a	Number of days covered by this disbursement. In 30-day increments. Anything less than 30 days should be reported as actual days supplied.
prv_name	Text	60	Should be "Maine Department of Health and Human Services" for all records

exp_service

Field Name	Data Type	Length	Description/Comment
srv_pk	Text	38	Simple primary key for table
srv_cln_fk	Text	38	Assigned ADAP ID
srv_delete	Yes/No	n/a	Default to False for all records
srv_subservice	Text	38	**Key to be provided during contract negotiations**
srv_date	Date/Time	n/a	Date formatted as mm/dd/yyyy
srv_quantity	Single	n/a	Units dispensed
srv_price	Currency	n/a	Unit price. CAREWare multiplies this times quantity to calculate the total cost for the transaction.
srv_subservice_label	Text	38	**Key to be provided during contract negotiations**
srv_contract_name	Text	50	Include column but leave all values blank
srv_category	Text	100	Should be “ADAP Insurance” for all records
prv_name	Text	60	Should be “Maine Department of Health and Human Services” for all records
cst_Drug_Name	Text	50	Name of drug dispensed
cst_Rx_Type	Text		ARV, OI, Other